KEPRO
INTELLIGENT VALUE

March 24, 2016

Lesley G. Erickson, CPPB, OPBC
Oregon Health Authority
250 Winter Street NE, Room 306
Salem, Oregon 97301

RE: Request for Proposal OHA-4140-16 Care Coordination, Integration and Evaluation Services

Dear Ms. Erickson:

This letter accompanies the response of APS Healthcare Quality Review, Inc. d/b/a KEPRO to the above-referenced Request for Proposal (RFP). KEPRO is pleased to accept the terms and conditions of the RFP and resulting contract if we are selected to continue our work with the Oregon Health Authority (OHA). We have read and examined the questions and answers and acknowledge Amendment 1.

The proposal builds on a sound record of achievement as it base: meaningful changes in utilization of services, strong return on investment (ROI) projected to exceed $80 million throughout the life of the current contract (an ROI of 3.1:1), high satisfaction among both Fee for Service and Dually Eligible clients, and a collaborative working relationship with OHA, the provider community, and other public and community-based stakeholders. Our local service center means that we are *in the community*, and *for the community*.

Even more important than the successful program we established in partnership with OHA is our commitment to *continuous improvement* in its effectiveness and impact. Our proposal reflects our ability to move forward with expanded clinical resources, new staffing as required and efficient implementation of the 1915(i) Independent and Qualified Agent scope of work. The integration of APS Healthcare and KEPRO brings together foundational experience and expertise in behavioral health, Medicaid and Medicare populations, and person-centered values to reach clients *where they are* – across the spectrum of health and health literacy, life experiences, and cultural perspectives. Our proposal increases and enhances our field-based approach, a hallmark of our programs that reflects our knowledge of Oregon's geography and populations. Our references demonstrate that our approach *meets contract requirements*; our flexible and responsive management style and record of results *exceeds our clients' expectations.*

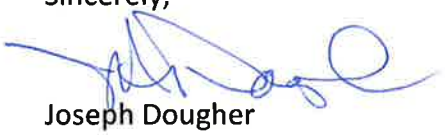
We project an estimate of over 33 staff members to complete the scope of work. With our knowledge of and experience with Medicaid waivers that provide home and community-based services to individuals with chronic behavioral issues, the Qualified Mental Health Professionals (QMHP) and other new employees who join our team will find efficient processes and systems that are reflect our status as a URAC-accredited organization and which represent best practices in eligibility determinations, independent assessments, and medical appropriateness. Just as importantly, our "person first" reputation in the behavioral health field for over twenty years will inform care plans that are recovery-oriented and build client resiliency.

The productivity of our staff members is exemplary and can only be magnified by the staffing model and operational approach we propose. In the most recent contract year, we engaged over 211,000 clients through telephonic contact – 124,000 Fee for Service Clients and 87,000 Dually eligible clients. Our community-based Registered Nurses conducted over 30,000 face-to-face meetings with clients – over 13,000 Fee for Service Clients and more than 17,000 Dually eligible clients. Extensive literature documents the difficulty in reaching the Medicaid population, and indicates that reaching the Dually eligible population is more difficult still. APS/KEPRO pioneered community-based care management and our results in Oregon continue to illustrate its effectiveness. With existing relationships on which to build in the new contract period, our engagement of Oregon clients will continue to make sustained and important differences in functional status, health-related quality of life, and appropriate costs of care.

The State of Oregon has a substantial record of leadership in Medicaid and a commitment to the Triple Aim by transforming the delivery system through a focus on primary and preventive care, evidence-based and culturally appropriate services, and effective management of care. Our commitment and ability to continue as a partner with OHA will support continued evolution of the delivery system with community-based, person-centered care coordination to "move the fragmented care to an organized and seamless delivery system of care."

We deeply appreciate the experience of the past six years to serve the State of Oregon and its Medicaid clients. Thank you for the opportunity to describe our plans to continue this service. If further information is needed, please do not hesitate to contact myself or Karen Eaton, Vice President of Growth and Development at keaton@kepro.com (717-265-7010).

Sincerely,



Joseph Dougher
President and Chief Executive Officer
KEPRO/APS Healthcare Quality Review, Inc.

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1. Proposal Certification Sheet (Attachment C)

ATTACHMENT C - PROPOSER CERTIFICATION SHEET

1. Proposer understands and accepts the requirements of this RFP. By Proposal submission, Proposer agrees to be bound by the Contract terms and conditions in Attachment A and as modified by Addenda, except for those terms and conditions that Agency has reserved for negotiation in the RFP.

2. Proposer acknowledges receipt of any and all Addenda to this RFP.

3. Proposal is FIRM for 180 days following the Closing.

4. If awarded a Contract/Price Agreement, Proposer agrees to perform the scope of work and meet the performance standards set forth in the final negotiated scope of work of the Contract or Work Order Contract.

5. Under penalty of perjury, Proposer certifies that Proposer is aware of and complies with the requirements found in OAR 125-246-0330. Upon request of Agency, Proposer shall provide supporting documentation.

6. Proposer does not discriminate in its employment practices with regard to race, creed, age, religious affiliation, sex, disability, sexual orientation or national origin. Nor has Proposer or will Proposer discriminate against a subcontractor in the awarding of a subcontract because the subcontractor is:
   - a minority, women or emerging small business enterprise certified under ORS 200.055, or
   - a business enterprise that is owned or controlled by or that employs a disabled veteran, as defined in ORS 408.225

7. Proposer and its employees and agents are not included on the list titled "Specially Designated Nationals and Blocked Persons" maintained by the Office of Foreign Assets Control of the United States Department of the Treasury and currently found at: http://www.treas.gov/offices/enforcement/ofac/sdn/t11sdn.pdf.

   Proposer certifies that, to the best of its knowledge, there exists no actual or potential conflict between the business or economic interests of Proposer, its employees, or its agents, on the one hand, and the business or economic interests of the State, on the other hand, arising out of, or relating in any way to, the subject matter of the RFP. Proposer shall provide prompt written notification to the State of any change occurring with respect to Proposer's business or interests which is reasonably likely to result in (or has resulted in) an actual or potential conflict between the business or economic interests of the Proposer and those of the State, arising out of, or relating in any way to, the subject matter of the RFP.

   In its notice, Proposer will describe the nature of such actual or potential conflict of interest or remuneration in question in reasonable detail.

8. Proposer certifies that all contents of the Proposal (including any other forms or documentation, if required under this RFP) and this Proposal Certification Sheet, are truthful and accurate and have been prepared independently from all other Proposers, and without collusion, fraud, or other dishonesty.

9. Proposer understands that any statement or representation it makes, in response to this RFP, if determined to be false or fraudulent, a misrepresentation, or inaccurate because of the omission of material information could result in a "claim" {as defined by the Oregon False Claims Act, ORS 180.750(1)}, made under Contract being a "false claim" {ORS 180.750(2)} subject to the Oregon False Claims Act, ORS 180.750 to 180.785, and to any liabilities or penalties associated with the making of a false claim under that Act.

10. Proposer acknowledges these certifications are in addition to any certifications required in the Contract and Statement of Work in Attachment A at the time of Contract execution.

Authorized Signature

March 24, 2016
Date

Joseph A. Dougher, President & CEO
(Print Name and Title)

2. Proposer Information Sheet

RFP OHA-4140-16 – *Care Coordination, Integration, and Evaluation* ATT D

ATTACHMENT D - PROPOSER INFORMATION SHEET

Proposer Name and Address		
D1	Legal name of Proposer	APS Healthcare Quality Review, Inc. dba KEPRO
	Address	777 East Park Drive
	City, State, Zip	Harrisburg, PA 17111

Contact Person for Questions / Contract Negotiations		
D2	Name:	Joseph A. Dougher
	Title:	President & CEO
	Address:	777 East Park Drive, Harrisburg, PA 17111
	Phone:	(717) 564-8288 ext. 7026
	Email Address:	jdougher@kepro.com

Proposer Information		
D3	Company Type (sole proprietor, partnership, etc.):	C Corp.
	Legal Entity Name	APS Healthcare Quality Review, Inc. dba KEPRO
	State of incorporation:	Delaware
	Date of incorporation:	June 16, 2014
	Federal Tax ID number	[redacted]
	Oregon Business Registry Number (if applicable)	1193880-98

Disputes/Litigation		
D4	Within the past 5 years, has Proposer been a party to a dispute with any customer in an administrative or civil judicial proceeding relative to the scope of this RFP? If yes, please explain below:	
	No	

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Proposer Minimum Qualifications			
	RFP Section	**Requirement**	**Meets?**
D5	3.1.1.1	Proposer must be legally qualified to conduct business in Oregon, in accordance with ORS 279B.110. Proposer shall provide its Oregon Secretary of State Business Registry number in its Proposal; or Proposer shall affirm in its Proposal that Proposer will register with the Oregon Secretary of State upon issuance by OC&P of the intent to award a Contract to Proposer. Registration must be completed before Contract will be executed.	Yes
	3.1.1.2	Proposer and subcontractor personnel directing care coordination activities should be licensed or certified to provide licensed physical health-related services and mental health services in the State of Oregon. Activities and resources may include or be augmented by personnel outside of Oregon but must be directed by Oregon licensed staff. Documentation confirming the license(s) must be easily identifiable by Agency and the Evaluation Committee.	Yes
	3.1.1.3	Proposer must have a minimum of five years' experience in providing coordination of healthcare services for state or federal health and human services programs. Evidence of Proposer's experience must be easily identifiable by Agency and the Evaluation Committee.	Yes
	3.1.1.4	Proposer must have a minimum of five years' experience with integration of multiple agency programs and systems, such as Medicaid and Medicare, telephonic triage, disease management, intensive care management, community outreach, and coordination of care. Evidence of Proposer's experience must be easily identifiable by Agency and the Evaluation Committee.	Yes

Proposer's Key Persons Minimum Qualifications *(expand this section as necessary)*			
D6	Key Person Name:		
	RFP Section	**Requirement**	**Years Exp**
	3.1.2.1	Proposer must have one, full-time equivalent (FTE), medical director position. Evidence of the position and its qualifications must be easily identifiable by Agency and the Evaluation Committee. A position description may be submitted, but Agency reserves the right to approve or deny the medical director if the position is filled after Award of thc Contract.	Please see Exhibit 1 Resumes
	3.1.2.2	Proposer must have one, FTE, clinical operations manager position to oversee care coordination and integration field staff. This position will be the primary clinical liaison with Agency's clinical reviewers and management staff. Evidence of the position and its qualifications must be easily identifiable by Agency and the Evaluation Committee. A position description may be submitted, but Agency reserves the right to approve or deny the clinical operation manager if the position is filled after Award of the Contract.	Please see Exhibit 1 Resumes
	3.1.2.3	Proposer must have one, FTE, behavior and mental health assessments manager position to oversee Work associated with the 1915i HCBS assessments, and other assessments required by Agency, and serve as the liaison between Agency staff and be accountable for that body of Work. Evidence of the position and its qualifications must be easily identifiable by Agency and the Evaluation Committee. A position description may be submitted, but Agency reserves the right to approve or deny the assessments manager if the position is filled after Award of the Contract.	Please see Exhibit 1 Resumes

3. Management Capacity and Capability

APS Healthcare Quality Review, Inc. d/b/a KEPRO proposes an integrated team of Oregon based and corporate leadership to ensure the continuity of knowledge and lessons learned from the current contract to the new and enhanced one. Extensive corporate resources of KEPRO will support our experienced, Oregon-based team. We include resumes for current staff members in **Exhibit 1 Resumes** and job descriptions for positions that will be filled prior to implementation.

Executive Director - John R. DiPalma. Mr. DiPalma has served as the Executive Director of the Oregon Health Plan Care Coordination Program (OHPCC) since June of 2012. He brings more than 20 years of healthcare leadership and consultation for the coordination and delivery of healthcare services. His extensive experience includes hands-on analytical consultation focused on process improvement, metric reporting, and operations design—leading to cost optimization and quality outcomes. During his tenure leading the Oregon team, Mr. DiPalma has led enhancements in the areas of reporting (both internal and external) and compliance. The program reduced OHA expenses approximately $60 million in five program years while driving improved clinical outcomes, including a return on investment of over 3.1:1.

Clinical Operations Manager – The Clinical Operations Manager is a full-time position reporting to Mr. DiPalma. KEPRO will fill this position with a doctoral level clinician, at least five years of experience with relevant responsibilities. The Call Center (Nurse Triage and Advice telephonic services) will report to this position, which will also be responsible for the day-to-day operations of clinical services.

Medical Director – Jeffrey McWilliams, MD. Dr. McWilliams will continue in his highly successful role, expanding his level of effort to full-time. He has close to 20 years of clinical delivery and consultation experience. He will serve as the program clinical expert and consultant throughout all phases. Dr. McWilliams is responsible for the quality and medical appropriateness of care provided to clients and ensures that we are compliant with state, regulatory and internal guidelines and policies. His contributions have been significant in building community relationships and improving clinical operations.

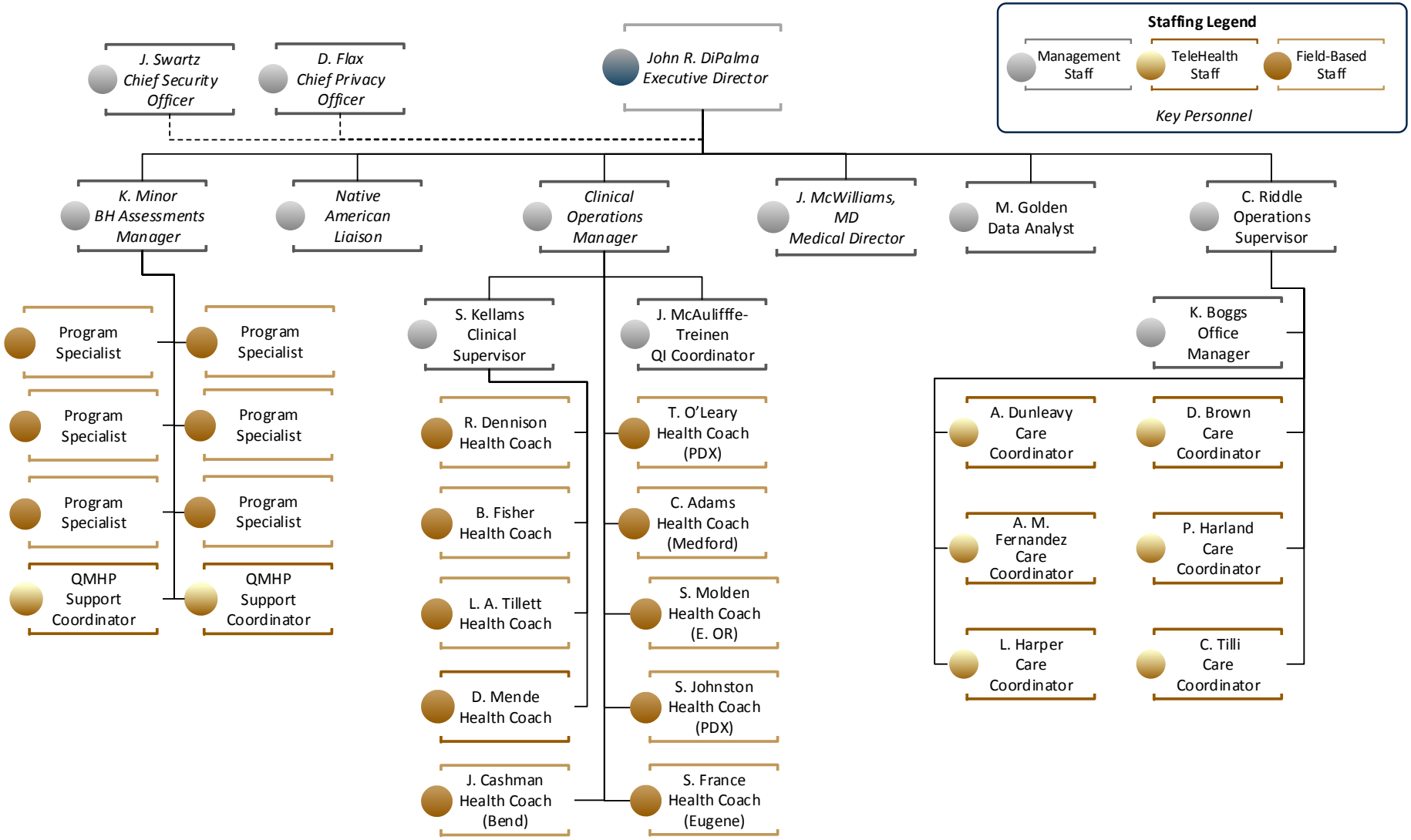
Privacy/Security Officer – KEPRO is a national organization with extensive federal contracts in civilian and defense healthcare, and manages the privacy and security of information at a corporate level. Dwight Flax, Chief Compliance & Ethics Officer is the Privacy Officer. Joseph Swartz, Vice President of Information Technology is the Security Officer.

Native American Liaison – As an organization with contracts in 34 states, KEPRO is aware of the importance of cultural competence to successful engagement with members and their families to improve health behaviors. The Native American Liaison will act as the sole point of contact for the OHA tribal coordinator, and attend meetings with the OHA tribal coordinator. The Native American Liaison will work collaboratively with the Clinical Operations Manager, Medical Director, and Behavioral Health Director to ensure staff is aware of cultural interests in all aspects of contract performance. KEPRO currently works extensively with various tribes and Medicaid's tribal specialists, such as Dennis Eberhardt. This foundation will enable us to meet the unique needs of tribal members using experienced KEPRO resources.

Behavioral/Mental Health Assessments Manager – The Behavioral/Mental Health Assessments manager will be a new position (Behavioral Health Director) on the KEPRO management team. A QMHP with a Master's Degree in a relevant field and at least five years of experience with Medicaid populations, this position will supervise all aspects of the 1915(i) assessments and care plan development. KEPRO brings twenty years of experience with behavioral health to the performance of this important aspect of the scope of work. Our experience encompasses all aspects of program management, including developing recovery oriented care plans collaboratively with individuals and providers. We are pleased to propose Kevin Minor, LCSW, in the position of Behavioral Health/Mental Health Assessments Manager. Mr. Minor is a current employee with KEPRO in the L.A. Care health risk assessment and in the process of re-locating to Oregon. As his resume reflects **(in Exhibit 1: Resumes)**, Mr. Minor is a Qualified Mental Health Professional with appropriate credentials for this position; his role will enhance our ability to implement the 1915(i) Scope of Work on a timely and clinically effective basis.

The project Organizational Chart is in Figure 1, demonstrating the extensive team that KEPRO brings to the project and enhances our readiness for July 1 implementation. **Exhibit 1 Resumes** also includes the KEPRO Operations Organizational Chart, indicating the team of professionals reporting to Meghan Harris, Executive Vice President and Chief Operations Officer. As this chart illustrates, KEPRO's current lines of business align with, and complement, the expanded scope of work – care management, assessments and care planning, and nurse triage/call center services for Medicaid populations. We also include Job Descriptions in **Exhibit 1** after the staff resumes.

Figure 1 Project Organizational Chart



4. Transition and Implementation Plan

COMPREHENSIVE TRANSITION AND IMPLEMENTATION PLAN. Our incumbency offers significant benefits for OHA and APD in the transition and implementation of the program. KEPRO will deliver a successful transition to new contract deliverables. Major portions of operations are well established, including data exchange (eligibility and claims); our care management platform, and triage, referral, data exchange, and reporting processes with Carenet for the Nurse Advice Line (NAL). Key members of our Management and Clinical Teams are in place, currently working with clients and collaborating with community stakeholders on behalf of client health. During implementation, KEPRO and the State will be able to focus on the customization and implementation of new program features—the best design optimizing outcomes for clients and providers. KEPRO will apply OHA resources cost-effectively to program enhancements and effective transition of IQA services. Clients will continue to experience high quality care coordination from a trusted care management team through seamless transition to the new contract with continued positive quality and cost results.

Our established relationships with OHA, APD, MAP, AAA, and other state support groups and services enables a rapid implementation of the new program without interruption to OHA and APD clients. A draft, high-level implementation timeline is included in this section. The plan also details larger strategy enhancements that include necessary steps to increase provider outreach; launch and provide ongoing education and technical assistance surrounding the Provider Portal; and consult with Health Intelligence and the State surrounding new algorithms to detect instances of uncoordinated care on a daily basis.

Highlights include:

- Steps to increase provider outreach and engagement with the program activities.
- Ongoing education and technical assistance to improve person-centered, evidence-based care.
- Consultation with Health Intelligence and the State for new algorithms to detect instances of uncoordinated care on a daily basis.

Human Resource efforts are also an important component of the implementation process with a comprehensive recruitment process focused on locating and obtaining healthcare professionals from Oregon who know the membership and the State. Our staffing model was redesigned over the past twelve months to include significant use of field-based staff and now includes field-based, licensed staff to support Independent and Qualified Agent services.

RESOURCES. KEPRO will perform all implementation work tasks and ensure that OHA and APD resources are appropriately applied. To help facilitate an effective implementation, we will work with OHA, immediately following contract award, to define and approve the Implementation Plan and to identify involved key State personnel. We will schedule a project kick-off meeting with OHA and recommend that KEPRO and OHA meet a minimum of once weekly throughout implementation. Meghan Harris, Executive Vice President and Chief Operating Officer will lead the implementation team, which includes: Julie Wright, Implementation Manager; Wayne Bolton, IT Implementation Director; Colette Riehl, Vice President of Operations, John R. DiPalma, Executive Director; Jeffrey McWilliams, MD, Associate Medical Director; and Ben Novinger and Melissa Golden, Health Intelligence and Reporting. KEPRO will collaborate transparently with OHA and welcomes the guidance of OHA to establish goals, metrics and benchmarks. The Implementation Team will have the full resources of KEPRO with specialists from major operations areas (Quality, Health Intelligence, Marketing and Communications, and Information Technology). KEPRO will produce weekly status reports for the State and the Implementation Team to track milestones.

PROCEDURES. We currently have established and proven procedures for contract Operations, secure data transfer for eligibility, provider and claims data. Files are compressed and through an automated, secure FTP method, inbound files are pulled from and outbound files are pushed to OHA's secure FTP location. This process will continue, subject to refinement during implementation. During implementation, we will review secure file transfer protocol with the State. An important area of consideration for revised policies and procedures concerns the IQA scope of work. KEPRO will review existing procedures and forms with the Agency and make adjustments based on our experience with multiple, similar programs as needed.

TRANSITION & IMPLEMENTATION TIMELINE. Table 1 Implementation Schedule and Activities presents the timeline for activities to implement the SOW. KEPRO Corporate resources will be responsible to finalize changes to meet new contract requirements and the proposed solution. The timeline assumes that OHA staff will participate in weekly status calls/meetings, in which updates and changes will be discussed and reviewed, and will then formally approve update materials, models, etc. The timeline also assumes that KEPRO will revise materials as requested following OHA/APD. As the incumbent, KEPRO is

currently able to accept full enrollment, begin assessments for all new members via IVR, telephonic and in-person contact, and will provide seamless transition to the enhanced program by July 1, 2016.

Ms. Wright will maintain the implementation plan during transition, along with a management process for any changes to the implementation plan. Weekly reports will document progress; milestones achieved; and identified issues, with suggested solutions. The proposed weekly implementation status call will then review this report, and changes to the timeline will be approved by OHA/APD after these calls. We will also update and submit a changed timeline.

Table 1 Implementation Schedule and Activities

RFP	Implementation Activity	Resources	4/22	5/13	5/27	6/10	6/24	7/1
◇ - Activity | ■ - Deliverable | ✱ - Milestone								
1	**Administrative & Implementation Activities**							
1.1	Notice of Intent to Award –4/22/16	OHA	✱					
1.2	Kick-off Implementation Meeting 5/2-5/13/16; Finalize Timeline	KEPRO, OHA/APD		✱				
1.3	Submission of Weekly Status Report	VP		■	■	■	■	■
1.4	Ongoing Implementation Status Calls – Weekly	KEPRO, OHA/APD		◇	◇	◇	◇	◇
1.5	CMS Approval of Contract – completed by	OHA/APD, CMS					✱	✱
2	**Scope of Work Implementation**							
2.4.1	*Care Coordination*							
2.4.1.11 Customize new assessments for FFS clients residing in Agency licensed Behavioral Health Treatment Programs		KEPRO Ops/IT/HI		◇	◇	◇	◇	
2.4.1.12 Customize Health Literacy Assessments		KEPRO Ops/IT/HI		◇	◇	◇	◇	
2.4.1.18 Edit process to eliminate potential barriers and identify solutions re: transportation, provider network, health literacy		KEPRO Ops/IT/HI		◇	◇	◇	◇	
2.4.1.19 Schedule and attend monthly treatment team meetings for Clients in OSH		KEPRO Ops		◇	◇	◇	◇	
2.4.1.20 Meet with Agency's TCM, Care Homes, CCO, providers, stakeholders to discuss strategies to avoid duplication of efforts and improve continuity of care		KEPRO Ops		◇	◇	◇	◇	
2.4.1.23 Revise processes to impact proposed outcomes		KEPRO Ops/IT/HI		◇	◇	◇	◇	
KEPRO submits materials for OHA/APD review and approval		KEPRO, OHA/APD				✱		
2.4.2	*Disease & Intensive Care Management*							
2.4.22 Review selection criteria, Update DM/ICM definitions and interventions based 2.4.2		KEPRO Ops		◇	◇	◇	◇	
2.4.2.5 Coordinate with Drug Utilization Provider		KEPRO Ops		◇	◇	◇	◇	
KEPRO submits definitions; OHA/APD reviews & approves		KEPRO, OHA/APD				✱		
2.4.4	*Independent & Qualified Agent Services*							
Create policy/process for 1915(i) HCBS initial evaluations/ revaluations for Eligibility Referrals, Scheduling, Face/Face Assessments, Plans of Care, Residential Treatment MA review.		KEPRO Ops		◇	◇			
Identify System configurations for Referral, Scheduling, Questionnaires/Assessments, Scoring, MA review, POC		KEPRO Ops/IT/HI		◇	◇	◇		
Draft workflows of complete process (receipt of referral, obtaining MR's, scheduling of F/F, completing assessment, MD review, and closing out with report)		KEPRO Ops		◇	◇	◇		

RFP	Implementation Activity	Resources	4/22	5/13	5/27	6/10	6/24	7/1
◇ - Activity | ■ - Deliverable | ✱ - Milestone								
Update website, materials for additional services on 1915 (i) HCBS services		KEPRO, MKT, Ops		◇	◇	◇		
Develop notices to clients and providers		KEPRO Ops		◇	◇	◇		
Conduct informational meetings at least quarterly at various locations statewide with the assistance of the CAC.		KEPRO Ops					◇	◇
KEPRO submits materials/updated P&Ps to OHA/APD for review and approval		KEPRO VP, QA				✱		
OHA/APD review and approve updated P&Ps		KEPRO, OHA/APD				■		
2.4.9	*Data, Records, & Reports*							
Provide OHA with Data Retention Policy		KEPRO IT			◇	◇	◇	
Provide sample 1915 (i)HCBS reports and prepare status reports as requested		KEPRO Ops			◇	◇	◇	
Submit data, records, & report plan; OHA/APD reviews and approves		KEPRO, OHA/APD					✱	✱
2.4.11-12	*Personnel & Key Persons*							
Review and finalize staffing model, current and new job descriptions		KEPRO Ops	◇	◇				
OHA/APD reviews and approves JDs and staffing model		OHA/APD			■			
Recruit, screen, hire, and train new positions, train/update current staff		KEPRO, OHA/APD				✱	✱	
2.4.13	*Information Systems & Technology*							
Document updates to System		KEPRO IT		◇	◇	◇	◇	
Provider Portal – Training, technical assistance & launch		KEPRO Ops, IT					◇	◇
Review changed/ new algorithms with OHA/APD for approval		VP/OHA/APD		◇	◇	◇	◇	
Conduct testing and final QA for go-live		KEPRO IT				■	■	✱
3	*Contract Go-Live*							
Readiness Complete for 7/1/16 Start Date –		KEPRO, OHA/APD					✱	■

KEPRO Value-Added Approach

During the prior contract period, KEPRO provided value-added services for prenatal care coordination. OHA provides notification when an OHP member is approved for out of hospital birth, at which point the member enters the fee-for-service population. KEPRO provides a dedicated RN Health Coach who engages with the member to facilitate an optimal clinical outcome. KEPRO also receives notice from OHA on new members who are pregnant. We outreach to the member to provide her with specific information and engage her in care coordination services. KEPRO is also investigating, with OHA, the use of incentives for compliance to particular protocols for women with previous pre-term complications or poor outcomes. This approach would be an additional aspect of the enhanced maternity care coordination services.

KEPRO proposes to enhance these services in collaboration with OHA. Additionally, we will create trigger algorithms to identify and prioritize interventions for women of childbearing age to promote early initiation of prenatal care, including automated calls and hardcopy/electronic notifications. We will also develop trigger algorithms for outreach to help women stay in prenatal care up to the births of their babies and make successful transitions to postnatal care.

5. Operational Plan

Our integrated operational model applies the Triple Aim to all activities of Section 3 Scope of Work (SOW). Our plan drives clinical and financial improvement – and incorporates social, behavioral, and community-based service coordination for a comprehensive, person-centered approach. We will help all clients achieve better health and access to needed resources by conducting assessments, developing customized Plans of Care (POC), coordinating care, developing self-management skills for health improvement, and engaging high-risk clients. We will help providers achieve better healthcare through practice transformation, e.g. evidence-based feedback and analytic reports. Our tools include comprehensive and conflict-free assessments and individualized care plans. We reproduce the Care Coordination and Independent and Qualified Agency workflow at the end of this section and provide larger versions in **Exhibit 2 Process Maps and Workflows**.

CARE COORDINATION AND HEALTHCARE INTEGRATION WORKFLOW

The KEPRO Operational Plan incorporates our existing program resources, includes enhanced staffing in several clinical areas, expands our operational model to include qualified assessment (IQA) and related behavioral health programs, and reflects efficiencies realized by leveraging our experience in all areas of the scope of work and our information system. This system is highly configured for Oregon's unique program features and will be further customized to support IQA activities.

Care Coordination

KEPRO offers a comprehensive, seamless, statewide program of care coordination and education services to all FFS and Dual eligible clients. KEPRO will conduct an initial assessment of all new clients identified by OHA. Our care coordination system identifies uncoordinated care and care gaps, proactively identifying clients most likely to become high risk or have a high-cost event. It also identifies the varying needs of the dually eligible, children or adult clients. Using eligibility, claims, assessment, census and other data, Percolator technology assigns an acuity level using Oregon-specific algorithms. It then identifies and prioritizes needs on a daily basis, creating client interventions. We then focus outreach and services on coordinating needs of high-risk and high-cost clients. A daily workflow queue applies evidence-based best practices and interventions to improve health outcomes; reduce costs and the progression of morbidity; and increase client activation. We will further tailor algorithms to new contract program goals and improve quality and outcome measures. Additional customization will increase existing focus on transitional services such as medication reconciliation and reduction of fall risks. Additional interventions will reduce hospital readmissions and potentially avoidable emergency room (ER) utilization. We will also place emphasis on improving access to Patient Centered Primary Care Homes (PCPCHs) , provide appointment assistance and follow-up, and coordinate health and support services in a culturally and language sensitive manner and explore more frequent data exchange to speed identification and stratification of clients, potentially receiving claims on a weekly basis.

KEPRO Value-Added Approach

KEPRO will continue to add value with our case management approach for members receiving highly expensive medication for Hepatitis C. Working with OHA pharmacy consultants, managers, the MMIS, KEPRO receives notifications for any FFS client approved for Hepatitis C program. We then engage them into our specialized care management program to ensure compliance with a very intensive drug regimen. Clients not in compliance with the prescribed drug regimen could be discontinued from further treatment.

Disease and Intensive Care Management

High-risk clients may receive telephonic and in-person support from CMs appropriate to their risk and individual needs, as well as a more comprehensive condition-specific assessment. DM topics include Diabetes, Asthma, Coronary Artery Disease (CAD), Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Cancer, Muscular Skeletal, as well as Depression, Anxiety and other behavioral health concerns including substance abuse. ICM candidates exhibit immediate or emergent acute care or transition needs, frequent inappropriate ER use or admissions, or present complex co-morbidities. These clients receive regular interventions, improving their health and quality of life. Services provided include in-person support within hospital/inpatient settings, discharge, transition, and coordination activities for all medical, behavioral, LTSS and social supports through entry into the community or a residential facility as appropriate based on clinical expertise. Coordination continues to ensure clients receive needed home-based care and support to prevent readmission to a hospital, slow the progression of disease and reduce the need for and/or intensity of long-term services and supports. Existing partnerships and processes with OHA's Targeted Case Management programs, PCPCHs, and Coordinated Care Organizations (CCOs) strengthen our ICM ability. We will maintain and expand on our existing relationships with OHA-

MAP and DHS-APD, clients, discharge planners at 59 hospitals, PCPCHs, and Aging and People with Disability (APD) Case Worker or Transition Coordinator, if appropriate, to provide safe discharges, smooth transitions of care and to ensure clients receive medical and support services for a healthy lifestyle.

Healthcare Integration

The Agency defined this element in the following way in the Questions and Answers:

> *Healthcare integration is the successful coupling of multiple scopes or types of healthcare to ensure the best holistic outcome in a person centered fashion*.

KEPRO is a pioneer in the development of person-centered care management, coordinating services across the spectrum of care settings for program clients for over a decade. Our "whole person" approach informs our staffing model, which integrates medical and behavioral health professionals for a comprehensive approach to service planning, and is based on our care management platform that integrates data about the client into an organized, person-centered record that reflects the medical, behavioral health, social, and environmental context of the client's experience. For clients in Oregon, this approach takes the form of an objective assessment that provides the basis for coordination of care, with a care plan that addresses all aspects of the individuals care needs. Our technical capabilities for integration match our person-centered culture, which derives from over 20 years of experience with behavioral health and developmental disabilities in all aspects of service – from direct service providers to Medicaid clients to fee for service utilization and case management. We are also adept at collaborating with clients to understand their goals and objectives; motivate them to improve their health behaviors; and provide supportive education to increase health literacy.

Healthcare integration means offering enhanced care coordination that unites services for clients for a seamless approach to medical, behavioral, and social contexts. We illustrate this approach in a number of ways that demonstrates our understanding of integration beyond traditional care coordination. Many OHP clients take multiple medications, a risk for drug interactions adversely affecting drug effectiveness or even creating adverse drug interactions. KEPRO performs numerous Medication Reconciliation assessments as part of care coordination, disease management and intensive care management services. Discussion are in progress with OHA's pharmacy program consultants at OSU who may be able to provide additional real-time pharmacy information, as well as professional consultation services to enhance the Medications Management functions that KEPRO provides through our RN Health Coaches.

Opioids and other medications with high-risk of abuse and addiction are a high priority for OHA. KEPRO is in discussions with OHA's pharmacy program consultants at Oregon State University to enhance collaboration and improve the ability of KEPRO RN Health Coaches to identify clients with potential for such abuse and addiction and facilitate early access to healthcare and social services. For clients who have special needs for durable medical equipment, KEPRO frequently assists them through Bridgeworks, a non-profit organization that acquires, refurbishes, and provides a wide variety of DME to people who need it at a fraction of the cost to OHA or others of buying or renting new equipment. When KEPRO staff learns about unused DME, they recommend donation to Bridgeworks.

KEPRO effectively coordinates care of fragile clients with the targeted case management program for Self-Sufficiency Services. Community-Based RNs throughout the state of Oregon communicate and collaborate with school-based clinics in coordination of care for children who are covered by OHP FFS Open Card. KEPRO Healthcare works effectively through County Public Health Departments with Cacoon, which is a statewide program assisting at-risk mothers and their babies. For clients in Multnomah and several other counties, KEPRO works with the State targeted case management services for substance abusing parents. KEPRO effectively coordinates care for clients with HIV with available resources, including the HIV services provided through the OHA pharmacy program consultants at OSU.

KEPRO collaborates with OHA's targeted case management services for people with hemophilia headquartered at OHSU and the pharmacy program consultants at OSU to enhance the coordination of service and medication management for the clients who require the very expensive treatments for hemophilia. The KEPRO Medical Director, Dr. McWilliams, has special expertise to assist with planning and managing care based on his background in hematology, oncology, and internal medicine.

KEPRO also meets with and works with Nancy Allen, who leads children's mental health services for the State, including evaluations and approvals for referrals to different levels of services. These services intertwine with various aspects of health,

healthcare, and other services. As needs arise for children served by the OHPCC Program, consultation with Nancy Allen is a valuable venue to collaboration with a variety of these services as may be beneficial for the ongoing care for these children.

Nurse Triage and Advice Line

KEPRO will continue our long-term relationship with Carenet for delivery of NAL services, fully integrated into our model. Carenet provides a toll-free, URAC-accredited and NCQA-certified Health Call Center, serving more than 20 million consumers worldwide, with a 69% ER avoidance rate; 71% rate of diversion from urgent care centers; and resolution of over 30% of NAL calls with at-home treatment. Services include screening for plan eligibility, evidence-based resolution algorithms, decision support, language translation, culturally sensitive triage and advice, and remote 911 report and hold capability. Client and State experience is seamless, with KEPRO accountable for all program components as the prime contractor. We have secure data exchange, triage, and referral processes in place, successfully directing clients to needed care and transitioning clients to KEPRO for follow up. We monitor, manage and report on Carenet results to ensure achievement of program requirements and performance and quality standards. A qualified and documented successful NAL ensures clients receive education and support after hours, expedites emergent situations and facilitates non-emergent situations through self/home care.

Independent and Qualified Agency

KEPRO is prepared to assume responsibility for this important program and has the background and capabilities to achieve seamless transition of services and effective performance of the scope of work. As Figure 1 Project Organizational Chart shows, the Behavioral Health Assessment Manager will report to Mr. DiPalma, and supervise a team of Qualified Mental Health Professionals. Staffing for this scope of work will possess credentials as Qualified Mental Health Professionals, licensed in Oregon. KEPRO will configure our information system for use with this program, and currently operates similar programs in West Virginia and Maine, where we review personal care, habilitation, mental health rehabilitation, and residential services including inpatient care, residential treatment facilities, and treatment foster care for example. This familiarity with technical and reporting requirements for the scope of work facilitates our ability to have the system ready by July 1, 2016. Field-based Case Managers will conduct eligibility determinations and assessments, with different Case Managers responsible to conduct medical appropriateness review. This approach, preferred by the Agency, introduces a system of "checks and balances" to assure that independent review for medical appropriateness promotes the necessity of services and level of care.

RESOURCES AND SYSTEMS

Staffing Model. Continuity of management from implementation/transition through operations is a significant benefit uniquely available from KEPRO. Our key personnel possess almost 70 years of relevant experience, and meet all education and experience requirements. Management ensures all professional staff members have and maintain required education and licensure, that staff capacity covers required hours of operation and interpretation services comply with Oregon standards. Using a comprehensive project plan, they map SOW requirements, deliverables, and milestones and assign responsibilities to achieve project goals. We document project plan performance and interventions through monthly reports discussed in Section 12. We propose additional field-based and client-facing staff for IQA services, to facilitate outreach, and engage clinical and community-based systems.

Information Systems. The KEPRO care management platform is a custom-developed, HIPAA-compliant information technology (IT) solution that integrates all program information and meets all requirements in 3.10. Together with KEPRO Percolator, it gives us the IT capacity and capabilities to administer the SOW. Televox and Compliance resources and systems such as SQL, SharePoint, and Business Objects are part of our technology solution. We exchange eligibility and claims data using Secure File Transfer Protocol. Our systems are compatible with the CDPS and the MMIS and adaptable to changes. KEPRO' security risk management plan protects all IT assets, to minimize the effect of security vulnerabilities and incidents. Release and access to records is guarded and provided on a need-to-know and provide service basis only, ensuring that PHI and medical information is released only in accordance with federal/state law.

SUBCONTRACTORS

With capabilities that encompass the scope of work, KEPRO proposes to augment our telecommunications and Call Center through continued subcontracts with Carenet for specialized Nurse Triage services and Televox for outbound call automation.

Carenet Healthcare Services (Carenet) will provide the Nurse Advice Line. A current KEPRO national partner, Carenet is a leading provider of healthcare support services currently working with more than 100 of the nation's leading healthcare organizations, delivering high quality healthcare support services to more than 25 million members. Their clients include a prestigious portfolio of healthcare organizations including commercial, HIX and non-profit health plans, clinics and hospitals, physician groups, employer groups, the US Military, and government-sponsored programs such as Medicare and Medicaid (managed and State). Clients such as KEPRO view Carenet as a valued partner and their services are an integral service offering for our clients.

Carenet has extensive experience, a proven record of success, and firsthand knowledge of providing Nurse Advice Line service to Medicaid clients. The approach for each new program is built on several fundamental elements: experience, culture, people, technology, flexibility, quality and proven success. Utilizing the same technology, protocols, evidence-based guidelines and staff, Carenet and KEPRO are prepared to deliver an industry leading – and URAC/NCQA accredited – solution that meets the State of Oregon requirements. All of the key Carenet personnel identified for the program are actively participating in or managing similar programs, ensuring that we deliver a low-risk, high-value solution to the State.

Outcomes across the national Carenet book of business include:

- At-home Treatment – 30% of Nurse Advice Line calls are resolved with at-home treatment
- Emergency Room Diversion – 69%
- Urgent Care Center Diversion – 71%
- Cost Avoidance - $32M

KEPRO communications, ER utilizer interventions, and health coaching strategies will increase the volume of calls to the 24/7 Nurse Line, enhancing results in Oregon and improving access to appropriate care.

TeleVox engages patients through voice, email and text appointment-based messages, helping them keep them on track with appointment reminders, recalls, and other follow-up visits. The KEPRO solution includes TeleVox to manage one- and two-way text messaging to engage clients, improve adherence to care plans, and deliver preventive and other reminders.

Televox results include, for example:

- Pikes Peak Cardiology has seen a 38% reduction in no-shows, which could mean $2.3 million in annual retained appointment revenue, since implementing TeleVox's HouseCalls.
- Automating appointment confirmations allowed Comprehensive Orthopedics in Salt Lake City to eliminate 50% of patient no-shows and reallocate $1,000 of monthly labor expense.
- Since delivering recalls and appointment confirmations through HouseCalls, Cardiology of Virginia has reduced communication costs by 68% and decreased patient no-shows by 27%.

WORKFLOWS AND PROCESS MAPS

Figure 2 demonstrates how KEPRO and Carenet coordinate activities for callers to ensure access to appropriate services. We include the overall care coordination process map in Figure 3 and the process map for Independent & Qualified Agent services in Figure 4.

Figure 2 Coordination of Calls with KEPRO and Carenet

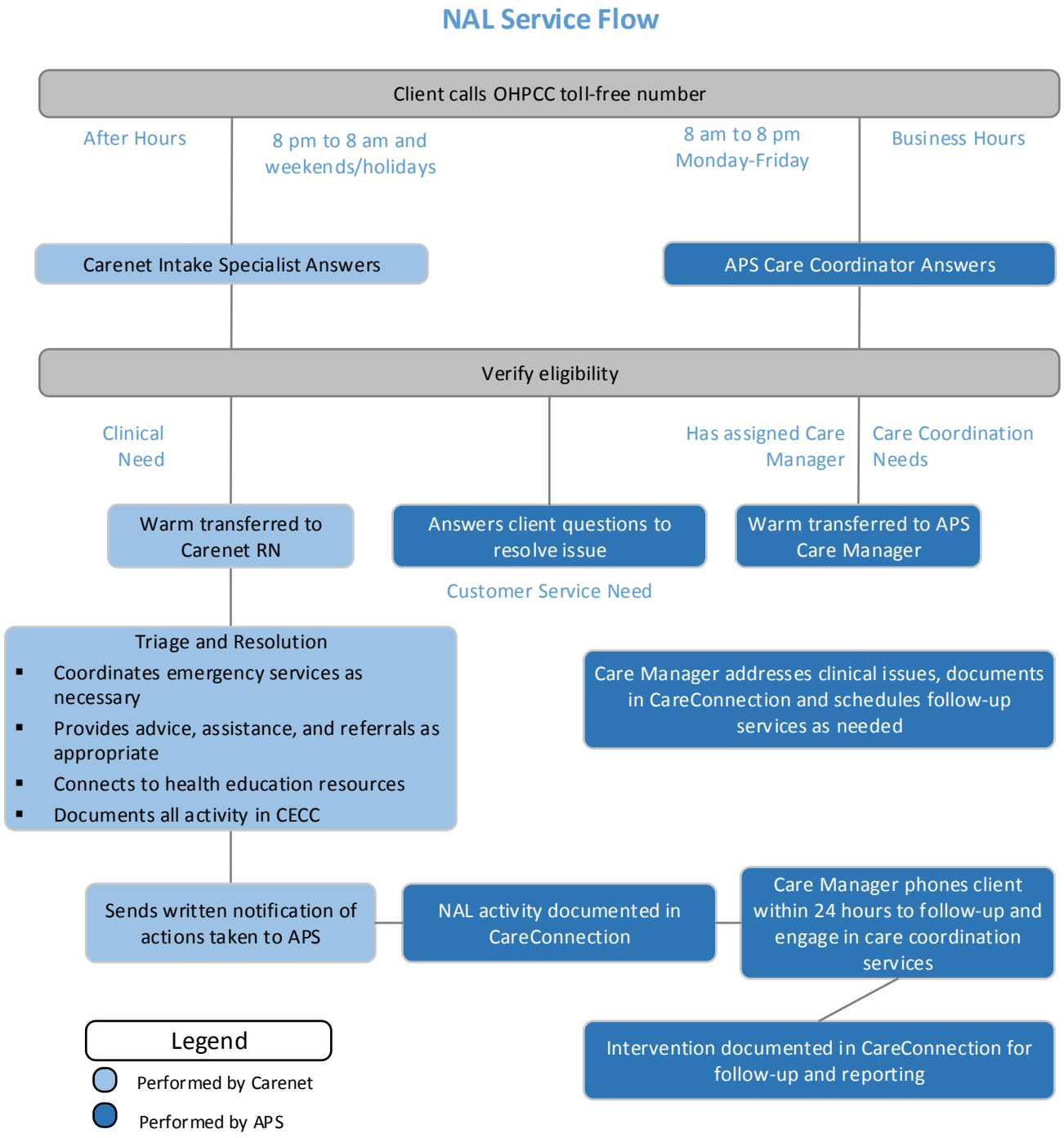


Figure 3 Process Map for Care Coordination, Integration, and Evaluation

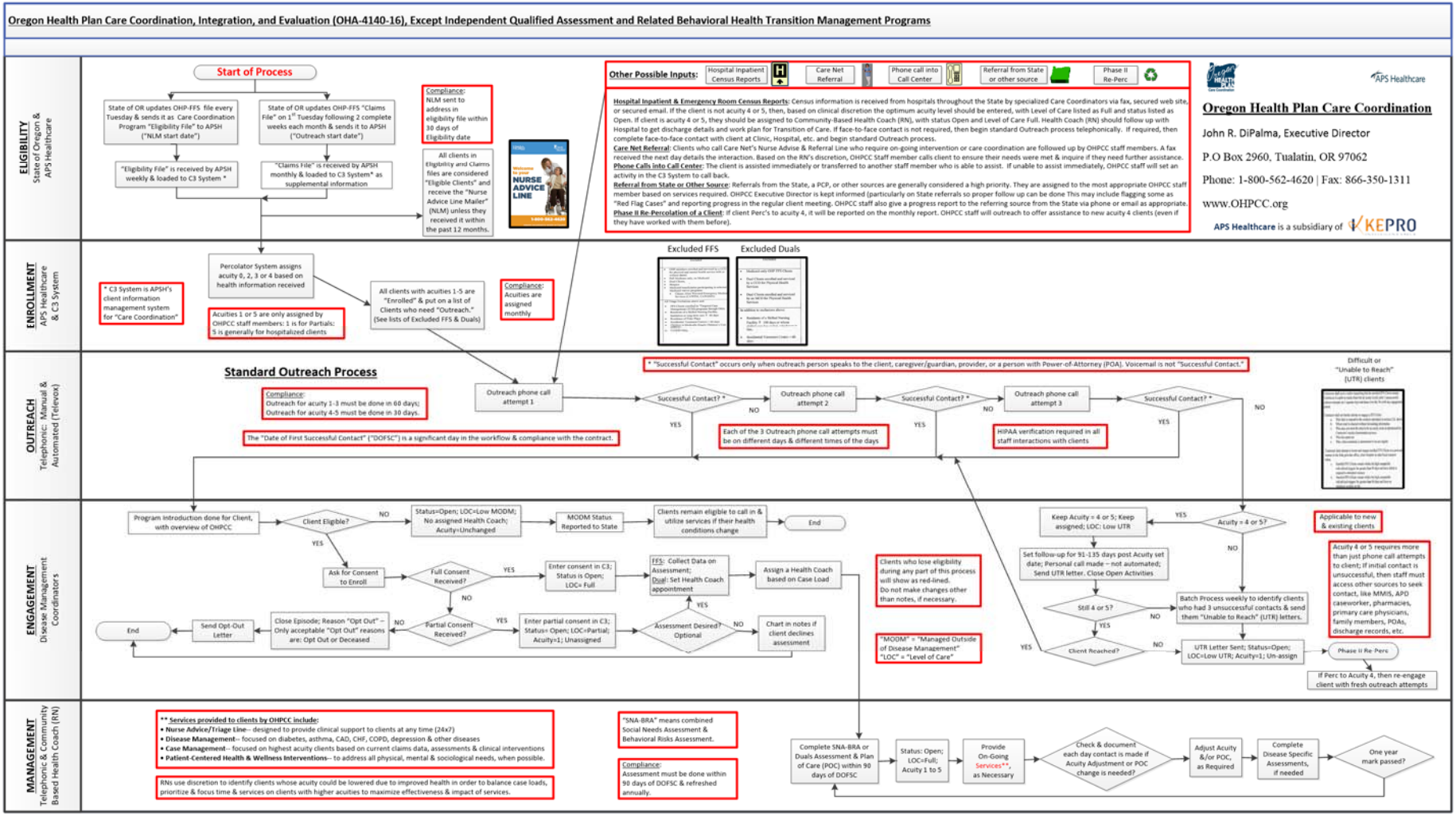
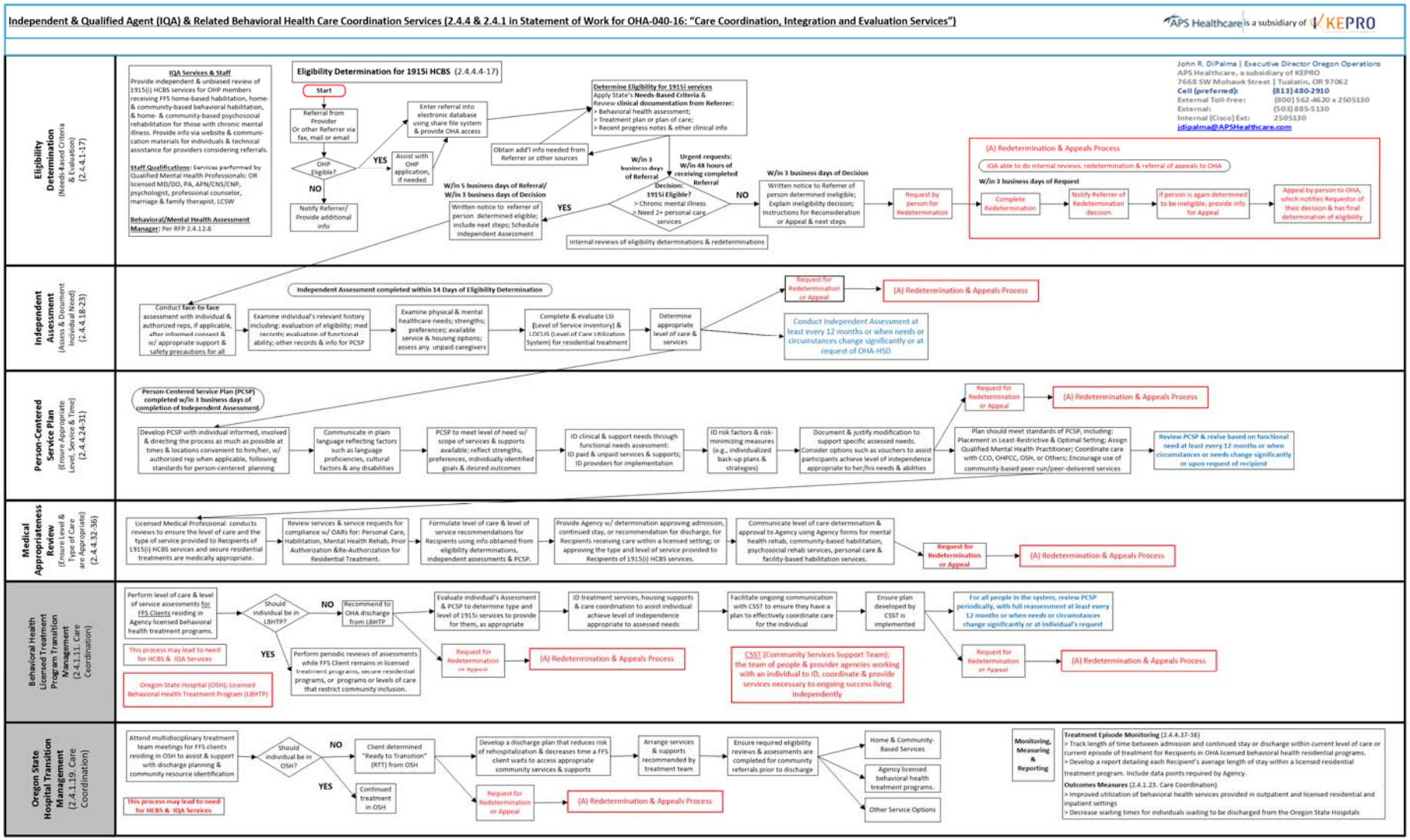


Figure 4 Process Map for Independent & Qualified Agent



6. Financial Condition

Exhibit 3 includes the Financial Statements for KEPRO. As these statements demonstrate comprehensively, KEPRO is sound financially, uses exemplary methods to manage our publicly funded contracts, and has the resources to complete all contract requirements to the satisfaction of our clients.

7. References

Exhibit 4 includes the letters of reference from current or former client firms for similar projects performed for public entity clients within the last five years.

8. Information Systems

SECURITY REQUIREMENTS/SECURITY RISK MANAGEMENT PLAN. KEPRO currently has access to OHA-MAP and DHS-APD computer systems and information assets and maintains a security-risk management plan that complies with all program requirements. We have an Electronic Data Interchange (EDI) Trading Partner Agreement with OHA and consistently comply with all OHA EDI Rules. Additionally KEPRO personnel have Individual User Profiles that control access to information, and are trained on privacy and security fundamentals, such as Health Insurance Portability and Accountability Act (HIPAA) and relevant state and federal regulations/laws. We have extensive documented policies governing processes that deal with all types of information, including protected health information (PHI). Our security organization, staffed with experienced security professionals, develops and maintains policies, audits compliance, and oversees implementation based around the National Institute of *Standards* and Technology (NIST) Standards. This organization reports to Joseph Swarz, the Chief Security Officer for KEPRO. Industry-standard security solutions support internal and external systems, with formal business continuity and disaster recovery preparedness plans. Our security risk management plan governs security baselines for these categories:

- Access Control
- Awareness and Staff Training
- Certification
- Security Assessments
- Configuration Management
- Contingency Planning
- Physical & Environmental Protection
- Incident Response Maintenance
- Media Protection
- ID & Authentication
- Audit and Accountability
- Personnel Security
- Risk Assessment
- Systems and Services Acquisition
- System & Communications

SECURE SHARING OF PERSONAL INFORMATION THROUGH ROLE-BASED SECURITY. The KEPRO system ensures information is made available on a "need *and* right to know" basis that protects PHI through user-defined roles and passwords. It supports Security Assertion Markup Language (SAML), implemented with a powerful identity and access management system featuring two-factor authentication (ID and password, token-based or device based) and authorization, single sign-on (SSO), HIPAA compliant role-based and policy-based access control, as well as auditing functions. The database is protected with the following security architecture: dual firewalls, internal or external users cannot access the database directly, restrictions to ensure that the only IP address permitted to connect to the database server is the application server, and security levels for system administrators, configuration managers and deployment personnel. Our role-based security implementation strictly follows NIST SP 800-53 and FIPS Publication 200 standards to protect the confidentiality, integrity, and availability of federal/state information systems, as well as the information processed, stored, and transmitted.

WEB PORTAL SECURITY. Security is provided based on confidentiality, integrity and availability of the data to clients or providers. KEPRO assures the State that information is kept confidential by using authenticated HTTPS sessions when entering the site. Users must provide credentials that require unique ID and strong passwords. Data returned is based on role and "need to know" for providers. Client access is strictly limited to the individual's personal account. Data stores are not directly accessible in the DMZ and are not stored in the DMZ. All data is maintained behind firewalls inaccessible from the Internet.

INFORMATION SYSTEM DESCRIPTION AND CAPACITY. KEPRO shares corporate technology resources, ensuring program access to significant experience with large database management and effective data exchange. Standard operations include a national information technology center responsible for transactions between client systems and KEPRO operations. Included in the data we receive are eligibility, provider, pharmacy, medical, behavioral health, lab, and encounter data for more than 15 programs on a daily, weekly, and/or monthly basis; as a managed health company we also act as a payer and create files such as eligibility, provider, and claims for use by clients and others. The KEPRO proprietary, HIPAA-compliant web-based care management application includes the Percolator system, our predictive modeling tool specifically designed to support daily analytics and identification of changes in risk on a daily basis. The Chronic Disease Payment System (CDPS) is also part of our predictive modeling process and embedded within the system. We manage data through an enterprise information architecture that is focused on movement, management, enrichment, and consumption of data. KEPRO employees use data management to ensure, maintain, and improve data quality as it flows throughout the organization. Our technology solutions feature:

- Architecture: Data and information flows through applications using a purposeful, managed approach that considers the enterprise to maximize data value and structure. An Operational Data Store receives data using ETL tools and applying semantic resolution, and then structures it in Data Warehouses for analytics and reporting.

- Security: Privacy and security information is managed by service level agreements (SLAs), auditing, and metrics development. We measure confidentiality, integrity, and availability. Preventive and corrective security controls are used to assure security of information.
- Performance: The KEPRO data architecture supports very high volumes of data with excellent performance. The infrastructure includes a clustered SQL backend, a scalable application tier, and a scalable load-balanced web front end. The system currently services 300 concurrent web sessions while running 100 concurrent SQL queries. The entire environment was stress tested with 1,000 concurrent user session and 1,000 SQL queries, proving it can support a minimum tenfold increase in user load. Application and web tiers can be scaled to support a theoretically unlimited number of concurrent sessions. The SAN that hosts the 42TB of data is scalable to 1.68 petabytes.

As an organization, we currently transmit over 1.3 million utilization review records using methods such as secured HIPAA/HITECH-compliant web services, SFTP, BSS, Internet, Diskette, tape-to-take, Iomega Zip, Castlewood Orb, and CD-ROM. For the Oregon contract, we currently use Secure File Transfer Protocols (SFTP) to support data exchange with the OHA-MAP and DHS-ADP as summarized in Table 2.

Table 2 Oregon Data Exchange Volumes

Data Type	Frequency	Volume
Eligibility (Lives)	Weekly	135,000
Provider Files	Monthly	110,000
Claims	Monthly	11,000,000

KEPRO Value-Added Approach

KEPRO will continue to support the extensive Provider & Resource Referral Database for Oregon Health Plan clients. KEPRO developed this resource during our seven years of contract history, including physicians, dentists, and other providers who serve Medicaid Open Card clients. We document information about the provider office, such as locations and hours. ***In the new contract period, KEPRO will enhance this listing with an indicator for dentists who provide sedation dentistry.*** This service approach provides a significant benefit for clients with developmental disabilities, for example, and builds on a national KEPRO best practice to improve the accessibility and safety of healthcare services for individuals.

DATA AND ANALYTICS SYSTEM. The robust capabilities of the KEPRO information infrastructure support data analytics with access to an integrated and organized database of claims, assessment, contact, intervention, and other information. KEPRO uses SAS for statistical analysis and business intelligence tools such as Crystal Reports to create standard and ad hoc data summaries.

KEPRO maintains a dedicated Health Intelligence (HI) unit which provides reporting and analytic services to support clients and account-level operations. The unit is responsible for report production and distribution, business intelligence presentation, and quantitative analysis for conducting evaluations and studies on healthcare programs. As such, HI serves both the Commercial (employer-based) and Public sectors. Our presence in each area allows us to share information and innovations across both markets. Maintaining these functions allows us to evaluate programs and effectively bring insights through customized analyses and reports that are timely, tailored, and meaningful.

The HI unit is staffed with both clinical and analytical professionals, specializes in delivering a full continuum of services necessary to improve care outcomes. We focus on program and policy evaluation; decision support and quality assurance services; data analysis and reporting; survey development and administration; and data validation and management. Our professional staff has worked with diverse administrative and reference data sources to produce thousands of analyses and reports on behalf of our clients. Our working knowledge of health care data includes Medicaid and Medicare administrative data, commercial health care claims data, state-level public health and human service administrative data, census data, public inpatient discharge data sets, and survey data.

9. Nurse Triage and Advice Telephone Services

Overview. KEPRO will provide all OHP FFS clients with 24-hour nurse triage and advice services. For the Oregon Health Plan Care Coordination (OHPCC) Program, KEPRO will continue to provide exemplary customer service, care coordination and follow-up services from our Tualatin Service Center. KEPRO consistently exceeded required service levels with an average speed to answer of 20.7 seconds and an abandonment rate of <2.2% for contract year 2015. We will continue to work with Carenet for Nurse Triage and Advice Line (NAL) services. Carenet is a URAC-accredited and NCQA-certified Health Call Center that has served more than 20 million consumers worldwide using evidence-based triage algorithms to determine appropriate levels of care for clients. Since 2009, the KEPRO-Carenet partnership has handled more than 500,000 calls using integrated workflows, data exchange, and referral and reporting processes. Clients who call 1-800-562-4620 receive customized attention and support—health education, help with benefits; and clinical advice and access to care coordination services. KEPRO monitors Carenet services closely, and we manage and report on NAL usage to ensure achievement of program requirements, performance and quality standards. The NAL uses evidence-based resolution algorithms and decision support. The service includes language translation and interpreter services, culturally sensitive triage and advice, and remote 911 report and hold capability. KEPRO follows up with clients who access the NAL to ensure questions were addressed; remove barriers to care; and assess the need for more intensive assistance. We prominently display the NAL number on all written client materials and the program website and promote availability of the NAL during all interventions.

Purpose, Objectives, and Goals of Nurse Triage and Advice Line. The Nurse Triage and Advice Line supports client decision-making, helping to decrease avoidable emergency room (ER) visits and hospital admissions. Its objective is to help clients make good healthcare choices based on evidence and clinical judgement. Across its book of business, Carenet has a 69% ER diversion rate, a 71% diversion rate for urgent care centers, and resolves over 30% of calls self/home care. This approach resulted in an estimated cost avoidance of over $32 million during 2015.

Using advanced technology and evidence-based software, NAL staff nurses triage calls, provide care recommendations for current symptoms, and answer specific health-related questions to provide assistance to 1) immediately address urgent health or suspected abuse issues, connecting with emergency services when required; 2) manage non-urgent injuries and illnesses through self-care or referrals to appropriate healthcare providers; 3) understand a specific diagnosis, condition or prescribed medication; 4) better understand and manage chronic conditions; and 5) empower healthcare consumers through education and support. NAL staff act as an entry point for information and answer questions on things such as wound care, disease management, and clinical urgency – enabling clients to make responsible health decisions such as avoiding unnecessary ER visits by using the services of an after-hours clinic. The NAL can also connect callers to an extensive audio health information library. NAL staff document all information and collect all pertinent data for clients' records. This data is entered into KEPRO' system for follow-up by KEPRO Care Managers within 24 hours. To help clients and their caregivers address a variety of health concerns, the NAL provides appropriate guidance in a clear and language-appropriate, culturally sensitive manner. Carenet provides Spanish-speaking staff at all times and has an on-call translation service that supports over 170 languages to ensure clear communication with clients, regardless of their primary language. Additional languages used by Oregonians include French, Korean, Russian, Cantonese, Mandarin, Somali, Spanish, Swahili, Vietnamese, and Arabic.

Positions Assigned to NAL Services. Our comprehensive staffing model supports effective service delivery and both KEPRO and Carenet staff are rigorously trained. Callers are paired with professionals dependent upon need. NAL staff comes from diverse backgrounds with certifications, degrees and experience in various fields including Emergency Medicine, Adult and Pediatric Intensive Care, Psychiatric/Mental Health, Diabetes, Administrative Management, OB/GYN, Pediatrics, Medical/Surgical, Disease Management, Neurology and Home Health Nursing. Carenet nurses must possess a nursing degree with current licensure. On average, these RNs have 5 years of nurse telehealth experience and over 18 years of clinical nursing experience. KEPRO CMs are licensed professionals with a minimum of 3 years clinical experience (RNs, LPNs and LCSWs); demonstrated knowledge of Medicaid/Medicare; and specific experience working with seniors and/or Dual eligible clients. Intake Specialists/Care Coordinators have a minimum of 1-3 years customer service experience in a position that required resolution of customer issues in the healthcare industry. Job descriptions are included in **Exhibit 1 Resumes**.

For all medical issues, an RN obtains the caller's medical history; performs a nursing assessment (including primary and related symptoms for the presenting problem); conducts an urgency/risk assessment; and identifies teaching needs. The RN also researches prior call history, and looks for any applicable cautionary information. Using the triage guideline, the RN recommends the most appropriate disposition. We provide information, instruction and education to clients on various health care options including self-care, emergent care, etc. or provide recommended timeframes for scheduling provider

appointments. The RN then assists in identifying appropriate clinical resources such as after-hours providers, verifies that the client understands what actions he/she should take, provides appropriate educational information, schedules a callback, and documents the call outcome.

Sophisticated technology augments the clinical expertise of the NAL RNs with embedded clinical guidelines and algorithms to guide client interactions. The CareEnhance® Call Center System (CECC) from Relay Health® is the central access point and data repository for NAL client information. Its triage module is equipped with decision tree functionality to support the nurses when delivering services. It improves clinical outcomes by providing intuitive access to safe and clinically proven information based on more than 400 triage guidelines, 1,000+ consumer-focused health topics, and 1,500 of the most commonly prescribed and over-the-counter medication topics. The triage guidelines focus on adult, women's health, behavioral health and pediatric health topics. The decision tree matrix begins with gathering information and continues through the triage assessment and subsequent questions to ensure Carenet provides consistent, clinically sound care advice to callers in accordance with annually updated and nationally recognized clinical guidelines. The system supports operational efficiency with intuitive tools to capture data, improve call processing, and track communication. It is configured to meet OHPCC needs and requirements, using an encounter tree that enables the users to navigate freely between multiple records and services. The system also features Healthwise Connect, a clinical application for productive conversations and efficient content access and validation of services. Healthwise Connect runs on top of the Healthwise Knowledgebase of consumer health information content that is rigorously reviewed by nationally recognized specialists from throughout the United States, Canada, and Europe. Another feature, known as the "150 Decision Points," provides the framework and information needed to assist clients to make informed health decisions regarding tests and treatment options. Use of these tools allows for consistent and appropriate care advice and self-care instructions.

Call Data is Recorded and Follow-up Conducted. RNs create a record of each call made to the NAL to document the client's understanding of the RN's recommendations, as well as the client's intended action and original inclination. A summary of the call is sent to KEPRO, entered into the system, and a KEPRO CM conducts a client follow-up within 24 hours. Data captured becomes part of KEPRO daily monitoring, and used to identify and prioritize clients' future needs for care coordination services. KEPRO monitors Carenet and KEPRO call center performance to ensure compliance. Measures tracked include number of calls, outcomes of calls, diagnoses, gender breakdown, number of calls and minutes by language, Average Speed of Answer, hold times, abandonment rate, duration, and incoming and outgoing transferred calls. This information is conveyed to the OHPCC Program and included in the Daily Scorecard, which is reviewed daily by leadership to monitor outreach and action taken. NAL data is part of the monthly, quarterly and annual reports. Quarterly reports include the number of calls per month by gender, top diagnoses listed in order, a breakdown of emergent and non-emergent call percentages and further breakdowns of advice provided to clients during the call. Annual reports include the number of calls per month and the top 10 diagnoses. Analyses of types of calls received are critical to identifying trends regarding conditions and patterns of care required. We have a well-defined Complaints and Concerns Process and a client satisfaction survey process that produces feedback on NAL services and informs our follow-up efforts and reporting to the State.

Carenet records 100% of both inbound and outbound calls and monitors calls using one-way monitoring, blind monitoring and a coaching model. Carenet performs analysis of randomly selected recorded calls monthly for each staff member. Other QA feedback is gathered through client surveys, test calls and calibration sessions. Automated call distribution (ACD) uses real-time monitoring to manage call flow, traffic, and trunk usage, and key metrics are analyzed to ensure adherence to URAC and contract standards. Quality assurance reports that include call volume; specific client issues and program results are shared with KEPRO monthly and monitored as part of our subcontractor-monitoring program. Carenet ensures industry compliance and security of client data. Carenet has passed all third-party security audits including the Statement on Standards for Attestation Engagements (SSAE 16), and meets the Department of Defense's stringent network equipment requirements.

Examples of NAL Procedures, Forms, Documents, or Reports. KEPRO will report NAL and triage activity for the State on a monthly, quarterly, and annual basis. **Exhibit 5 Nurse Triage** includes Policy and Procedures for the NAL service, follow-up, referrals, and monitoring. **Exhibit 8 Reports** includes sample Cost Avoidance Report that demonstrates an estimated cost avoidance based on the caller's original inclination for care compared to the nurse's recommendation.

Telehealth Services. Carenet offers one of the most advanced telehealth networks in the nation, seamlessly integrated with their Nurse Advice and Triage service. They can offer referrals through their RNs, based on approved criteria, for physicians and providers who are licensed in the State of Oregon to provide telephone or video consultations on 24/7/365 basis. We look forward to discussing the possibility of adding these services to the array of innovative programs OHP clients can access.

10. Care Coordination Services

Purpose, objective, and goals. As a leader in the development of innovative delivery systems, OHA's vision establishes goals for this program in the context of improving lifelong health for the people of Oregon. The process of person-centered care coordination, integration of services across settings and providers, and continued evaluation of service effectiveness and efficiency provides the purpose and objectives for this program—to improve quality of life by helping clients improve health literacy, utilization, and self-management; increase the involvement of clients and their families in decision-making; and provide actionable information providers and OHA can use to improve the availability, utilization, and quality of the community-based, integrated health system. The purpose of this program is to provide measurable and effective clinical interventions to improve health literacy and health behaviors. Additional support to improve access to medically necessary care comes from our comprehensive Call Center, with local Care Coordinators during business hours and the 24/7 Nurse Advice Line available after hours. We are accountable to the State of Oregon to increase the effectiveness of care; eliminate avoidable services; and reduce per capita cost. KEPRO has a record of achievement to this end: achieving a 3.1:1 return on investment in Oregon and improving key metrics.

Care Coordination Services. KEPRO will provide integrated care coordination services that span medical, behavioral, dental and LTSS needs to all Medicaid and Dual eligible clients, in compliance with Statement of Work (SOW). Our person-centered model enhances clients' quality of life; focuses on appropriate care to achieve improved health; and results in decreased cost—all goals of Oregon's Triple Aim. Programming uses evidence-based practices, interventions, and strategies, aligned with program goals, to achieve improved clinical and financial outcomes. We deliver health education and promote behavior change for improved self-management and healthy lifestyle choices across the membership. KEPRO monitors the health status of all clients and provides all clients with services focused on prevention to help clients remain independent---including the Nurse Advice Line and Triage (NAL), assessments to gauge health status, customized plans of care (POC), and help identifying and building relationships with Patient Centered Primary Care Homes (PCPCHs). KEPRO provides other care coordination services such as appointment assistance, referrals, and a wide array of support dependent upon clients' unique needs to ensure that improved health outcomes are achieved, barriers to care eliminated, and that duplication of efforts and continuity of care between delivery systems is achieved through collaboration with PCPCHs, OHA's Targeted Case Management programs, and Coordinated Care Organizations (CCOs). Our program is focused on both short- and long-term strategies to improve health status, healthcare delivery, and cost of care. We provide a detailed workflow diagram in **Exhibit 2 Process Maps and Workflows**.

We monitor all clients and assign targeted clients to a Care Manager (CM) to improve access to PCPCHs and close gaps in care (e.g. routine annual exams and self-management of chronic conditions) to improve healthcare utilization. We outreach to all clients for assessments, development of POCs, and delivery of health prevention. KEPRO also works closely with high-risk and high-cost (HR/HC) clients to change individual healthcare utilization, remove care barriers and increase healthy behaviors to reduce progression of chronic conditions and reduce inappropriate use. Through daily monitoring and prioritized outreach, we target care coordination services and interventions for high-risk/high-cost (HR/HC) clients with chronic disease or intensive needs, and/or frequent Emergency Room (ER) utilization. KEPRO ensures that medical treatment is appropriate, timely, and cost-effective and support services are available. Our care management platform supports these strategies with a web-based, HIPAA-compliant system. It administers individual risk stratification, assessments, and care planning, and houses care management tools – data, guidelines, plans of care (POC), health assessments, communications, and interventions – in a single site accessible to the care management team and providers. A person-centered data repository that combines client-specific data with predictive modeling, it promotes productive interactions among the integrated care team to address the wellness of each individual comprehensively. This system tracks and reports client and provider information, including interactions, assessments, and interventions. This model is proven in Oregon through the current Care Coordination Program that began in 2009. Building on our program model that delivered $80 million in savings over the past six years, KEPRO introduces new tools and strategies in this proposal to achieve Oregon's Triple Aim.

Screening for Risk Factors and Health Status/Stratifying Acuity Levels. Our risk/acuity framework is a system of weighted algorithms that we apply to client-specific data to create a comprehensive risk score documented in our system. We use six acuity rankings, zero to five, to represent the risk, acuity, and need levels of clients based on clinical, functional, and social needs as well as patterns of risk and resource requirements. Regardless of acuity level, all clients receive initial outreach for completion of a customized and comprehensive health risk assessment (shown in **Exhibit 6**), completion of an individualized POC, and are included in preventative reminders sent membership-wide for topics including annual exams, flu shots, and Early and Periodic Screening, Diagnosis, and

Treatment (EPSDT). Members of a higher risk receive additional outreach and support in the form of Disease Management (DM) and/or Intensive Case Management (ICM) dependent upon acuity level and individual needs. Appropriate levels of care management are delivered equitably based on client needs, which are assessed daily using all captured data. The Percolator, a system of evidence-based and weighted algorithms, detects instances of uncoordinated care and stratifies clients daily. The system uses information to create a prioritized list of HR/HC clients, sorted based on uncoordinated care and treatment gaps. The system utilizes CDPS[i] and is configured with algorithms (triggers) through a proprietary uncoordinated care analysis that includes over 1,000 algorithms (e.g., HEDIS® performance measures and public domain measures such as the Prevention Quality Indicators published by the Agency for Healthcare Research and Quality), as well as customized triggers for Oregon clients. The Percolator applies algorithms daily across the entire population, updating the workflow and risk score for clients with changes based on recent healthcare utilization or other information. This information includes, for example, State data feeds, outreach and interventions, NAL calls, referrals, and inpatient census data from hospitals across Oregon. KEPRO screens data for clinical indicators as well as long-term care factors, which is particularly relevant for dually eligible clients who may have fewer significant long-term care issues and costs. Clients with higher risk scores are prioritized for intervention. A relative weight is then applied using a "sliding scale" based upon frequency and timeliness of events. For example, a client with a frequent ER-use trigger and an ER visit within the last month would receive a higher weight than a client who last visited the ER visit two months ago.

> Originally developed for one of the first care management programs to integrate medical and behavioral healthcare care management, the KEPRO system is ideally configured to integrate 1915(i) waiver members into the comprehensive care coordination program.

KEPRO monitors utilization across the entire membership, acuity levels zero-five. Our technology produces three important ranking queues among clients identified within acuity levels one-five: 1) across all clients to ensure that all eligible clients in acuity levels one-five are identified for outreach and engagement; 2) to identify those clients with the most urgent and treatable needs for immediate contact; and 3) on a client-specific basis, to assure that issues identified for that client are prioritized for attention. Multiple components determine a client's position in the queue:

- Acuity Level – client costs, complexity, admissions/readmissions, and use of health and long term care services through the program. All clients are outreached via telephone and HR/HC clients receive in-person outreach and support.
- Number of triggers such as: lack of Patient Centered Primary Care Home, avoidable inpatient or ER visits, multiple ER visits, lack of ambulatory care, HEDIS-related gaps, suboptimal medication profiles (polypharmacy, non-adherence, and inappropriate use), risk of entering long term care or contract requirements for frequency of outreach.

After stratifying all clients, the system prioritizes workflow for CM outreach. Specific triggers for prioritization vary from complex socioeconomic issues that impact a client's ability to access appropriate care to simpler needs for condition-specific education. The system organizes queues for clinical interventions as well as non-clinical interventions. To address the identified trigger (depending on the health status of the client), a CM may administer additional condition-specific assessments, e.g., the diabetic assessment, as well as conduct evaluations of the client's social needs (stable housing, transportation, health literacy, caregiver support, community resources). By running the process *daily*, we are able to continually prioritize clients who need immediate outreach and intervention using all available data captured in the system: assessments, claims and eligibility, inpatient census data from hospitals across Oregon; referrals; and from clients who call the NAL. CMs contact clients based on the client's individual, changing needs with more frequent "touches" for higher-risk clients. KEPRO accurately identifies and manages clients enrolled in the program at the most appropriate level of intervention with contact occurring in accordance with the client's unique clinical and social service needs.

Conducting Assessments. In accordance with SOW, KEPRO will conduct outreach to all new clients identified by OHA to attempt to conduct an initial assessment within 30 days. KEPRO has developed a customized assessment (**Exhibit 6**) that will gather medical, behavioral, psychosocial and basic social support information across the membership. The initial assessment, aligned with NCQA guidelines, determines: diagnosis and medical history; the presence or absence of routine sources of care; signs and symptoms associated with chronic illness; primary disease processes and co-morbidities; treating health professionals and medications; cultural factors about healthcare that influence access, receptivity, or service provider behavior; social support; and risk for depression and substance abuse. Assessment results are captured within each client's individualized record and are used to engage clients in care coordination, DM, LTSS or ICM services, as appropriate. KEPRO conducts additional specialized evidence-based assessments, i.e. medication reconciliation for clients engaged in DM and ICM, and for chronic conditions such as Asthma, Diabetes, Coronary Artery Disease, Congestive Heart Failure, Chronic

Obstructive Pulmonary Disease, etc. to collect information on specific chronic conditions. We also identify the need for specific clinical and functional assessment through the identification and stratification process, using claims and other data.

Developing/Using the POC. KEPRO will develop a POC for each client based on information available. Assessment, claim and other data captured auto-generates a POC. The POC is an action plan that documents client goals and the interventions and resources (whether available on the OHP Prioritized List of Health Services and FFS Client's benefit package, through another agency, or available as a community resource) that will support their attainment. The CM augments and modifies the POC if the client is of higher acuity and engaged in DM or ICM services. As part of the POC, the CM works with the client and authorized family member and/or trusted resources to develop manageable short- and long-term goals for the improvement of the client's health and well-being. Each goal and objective has designated timeframes for follow-up, re-evaluation and completion. Based on acuity, complexity and individual needs (e.g., acute exacerbation of disease, care transitions), the need for extensive collaboration and coordination of care may be required. The CM may initiate a discussion with the Medical Director, the client's PCPCH, and/or specialist provider as part of the treatment planning process. Using the client's POC as a guide, we work cooperatively among health plans, social service agencies and treating providers to help clients gain access to needed medical, behavioral health, social, educational and other services to optimize health and quality of life. Throughout the client's enrollment, the CM monitors client progress and initiates changes and updates. A formal review of the POC is prompted at the following times: when the first goal is due; when a new problem is identified; or when there is a change in the client's health status.

Providing Interventions. KEPRO provides coordinated health care and customized interventions to meet medical and support needs, help clients practice better self-care, emphasize the importance of provider care instructions, and prevent unnecessary admissions and re-admissions through discharge planning and in-person support to assist clients and their support circles with transitions of care to ensure the right care in the right setting, with independence always the goal. Our CMs are trained to focus outreach and support on prevention. We conduct telephonic and in-person interventions with clients that include assessments, care coordination, and education and support that covers basic prevention and the prevention of chronic conditions, or necessary management to integrate medical and behavioral needs. The frequency and duration of interventions varies but may include eligibility verification; response to basic questions; removing barriers to receipt of needed care and services; PCPCH integration; appointment scheduling assistance; referrals; coordination of basic needs such as transportation or medication refills; and other basic support and coordination information.

The system analyzes all available data daily to prioritize clients for outreach and leverages evidence-based best practice guidelines built into system functionality, prompts, and queues used by CMs and captured within individual client records. Interventions are tailored to client self-management skills, and address behavioral health factors or any psychosocial or basic needs to ensure effective interventions in light of the client's assessed needs (e.g., at risk for depression, substance abuse, or uncoordinated medical and behavioral care). Clients who are high risk and/or high acuity receive Intensive Case Management (ICM) that involves in-person support within residential or facility settings and close follow-up and communication with clients, providers, family members, and support agencies. Client-facing staff will also provide education focused on removing barriers to care and improving health literacy. We provide more than 12 disease and condition support programs, and wellness coaching for nutrition, exercise, smoking cessation, etc. Interventions also include automated outbound messages (Televox) with preventative health reminders. We propose the addition of a maternity/pre-natal care program, as Medicaid programs have been identified to have a disproportionate spend for this population. The maternity/pre-natal care program includes outreach calls to pregnant clients, assistance with the scheduling of prenatal doctor visits, educational materials to promote a healthy pregnancy, and access to the NAL.

Determining, Tracking, and Monitoring Metrics. KEPRO will develop metrics with OHA and APD to ensure all clients are contacted, assessed when willing, and all interventions aim at achieving health outcome and engagement goals. Metrics will conform to both CMS and State requirements, will align with those used by the CCOs, and, when appropriate, may be specific to particular enrollment groups like dually eligible, Medicaid-only, children or individuals with a particular condition. We will use them to evaluate health and education, promote clinical improvement, help close gaps in care, improve access to support services and control the growth of Medicaid spending in alignment with OHA's goals. Examples of health outcomes for previous emphasis included all cause readmissions, ER utilization, ambulatory care, comprehensive diabetes, admissions for COPD/Adult Asthma and CHF. For dually eligible clients, slowing or reducing the need for, and entrance into, long-term care is of special interest. We will also use HEDIS, CMS Adult Medicaid Quality, CHIPRA and other outcome measurements to track and report on clinical and financial outcomes. We will target interventions to achieve agreed upon metrics, and will work

with, share, and compare our results with CCOs. KEPRO will track outcomes within the system using all available data sources including data from the State, as well as all data captured from assessments and during the course of program delivery. We also monitor NAL performance, population demographics, engagement, acuity movement, assessments, call center performance and client satisfaction to ensure that operations achieve the agreed upon metrics.

Staff Qualifications. The KEPRO model uses Interdisciplinary Care Management teams of field- and office-based CMs. We require Care Managers to become certified Case Managers within one year of hiring. Each team is led by a Registered Nurse (RN) who has the support of Licensed Practical Nurses (LPNs), Licensed Clinical Social Workers (LCSWs), and Care Coordinators to conduct client outreach and support based on client need and staff role in care coordination delivery. We base client engagement on documented individual need aligned with qualifications of staff members conducting outreach and engagement. KEPRO teams receive clinical consultation and guidance from the Medical Directors, including lead Medical Director, Jeffrey McWilliams, MD. CMs are licensed professionals with a minimum of three years clinical experience (RNs and LCSWs) or minimum two years clinical experience (LPNs); demonstrated knowledge of Medicaid/Medicare; and specific experience working with seniors and/or dual eligible clients. We also prefer our RNs to possess certification as a case manager. Staff is trained in motivational interview techniques and other methods to build trusting relationships with clients that are mindful of each client's level of readiness, strengths and motivation. Care Coordinators have a minimum three years customer service experience specifically in call center environments; demonstrated knowledge of Medicare/Medicaid; and knowledge of the healthcare industry.

Engaging and Maintaining FFS Clients in Care Coordination Program. KEPRO attempts to engage clients telephonically, in adherence with all protocols and timelines. Clients with high or moderate acuities are contacted within 30 days of receipt of the claims data and those with lower acuities are contacted within 60 days. Our interdisciplinary CMs will also work across Oregon to engage clients with face-to-face interactions. We balance the importance of basic prevention for healthy clients with intensive engagement to prevent negative outcomes in those at greatest risk. Our goal is to keep clients engaged and involved in their care and its coordination, regardless of acuity level. We involve clients in the establishment of attainable goals and then provide on-going outreach to motivate and assist with their achievement and engagement. We provide all clients with health education, the NAL, care coordination services such as appointment assistance and help locating a PCPCH, and online materials. We plan to include an automated call process (Televox), in addition to live person calls, to assist with initial client outreach and completion of initial assessments. We also provide a Welcome Package introducing the OHPCC Program to newly eligible clients weekly that explains their rights, responsibilities and program benefits. The Welcome Package includes descriptions of the services that are available to all eligible clients including the Nurse Advice and Triage Line services. In addition to telephone calls and welcome packets, we send newsletters, disease-specific mailings, preventative care reminders, action plans, and separate reminders about access to the NAL.

KEPRO proposes to engage specific populations based on analyses of population need such as pregnant women or OHPCC reports of those with tobacco usage. We will expand automated calls to the entire membership to include general preventative outreach for flu vaccine reminders and other routine needs such as annual exams, with an option to transfer to a KEPRO staff member. We also recommend the addition of targeted calls to population segments, e.g., a Televox call to all women who are of childbearing age about prenatal care and support available through the program, to the ability to use the NAL for assistance with their concerns.

Recipients of care coordination programs are often short-term in nature, being eligible for only a few months. With the OHA goal of serving as many clients as possible in CCOs, that is a likely scenario with clients enrolling in the OHPCC and then rapidly moving into a CCO. New or short-term clients may be difficult to impact with traditional care coordination and often have a higher than normal ED and inpatient utilization. To influence this segment, KEPRO will focus outreach, primarily using Televox and mail, to emphasize the NAL and the many educational materials available to all OHPCC eligible clients. The clients will receive information in the New Member Enrollment Packet detailing on-line resources for health education and reiterating the value of the NAL and the importance of finding and using a primary care physician. In our experience, Medicaid maternity clients often have a very high ER visit rate, frequently over 3,000 visits per 1,000 clients with more than 50% of those visits non-emergent. Focused emphasis on the NAL, pre-natal care, on-line resources and mailed educational materials will provide assistance to raise their health literacy, improve their health care and empower them to manage their healthcare.

Transitioning FFS Clients to a Higher or Lower Acuity Level of Care. Our objective is to transition clients to lower levels based on our interventions and customized support, with daily stratification identifying clients who can benefit from interventions. Our interventions are customized to clients' needs at any point within the healthcare continuum, to create a

seamless transition between acuity levels. As members become more engaged, they are better able to manage their health conditions and actively participate in their healthcare and ultimately reduce population risk. To ensure they receive appropriate interventions, KEPRO's technology prioritizes, or "percolates" members daily based on changeable events. By assessing all incoming data (claims, assessment data, referrals, and information captured from previous interactions with the program or NAL) daily, we are able to determine when a transition to a different level of care is needed.

KEPRO currently stratifies the membership into six (6) acuity levels, 0 through 5. Acuity 0 is little to no risk, or has no claims data available; Acuities 1-3 are considered low to moderate risk; and Acuities 4 (high-risk) and 5 (very high risk) are of higher risk and are determined by an RN or Medical Director to be at risk for a severe or an acute event and require ICM. The daily re-prioritization based on changeable events and client achievement of short-term goals, keeps our care management staff reaching out to those clients who are most in need of assistance. It also keeps staff focused on clients' individual and changing needs with more frequent touches for higher acuity clients.

Accessing and Utilizing Expert or Specialty Community Resources. Outreach within the community is an integral program component. KEPRO established, and maintains, positive relationships that have improved and will continue to improve access to care and foster increased and comprehensive care coordination. In addition to OHA and DHS supported organizations, KEPRO maintains a Resource Database of expert and specialty community resources that supports our identification and referral process. We update the database regularly, including contact information for state, non-profit, and for-profit organizations throughout Oregon. We frequently work with the American Cancer Society, the National Institute on Aging, Meals on Wheels, the Oregon Alzheimer's Association, the Lion's Club, the National MS Society, the American Lung Association, the American Diabetes Association, the Commission for the Blind, and other local charities and organizations. We have and continue to develop relationships with housing authorities and housing support groups to help meet social needs and integrate those needs with their health and other support needs. We maintain a Clinical Advisory Committee (CAC) consisting of stakeholders from KEPRO, OHA, and community organizations. The CAC enhances partnership among entities and provides an open forum for collaboration and communication on the behalf of the OHPCC and its clients. We collaborate closely with clients, facility discharge planners, PCPCHs, and Aging and People with Disability (APD) Case Workers or Transition Coordinators to identify available resources, coordinate referrals to social service and informal supports, and promote an understanding of and adherence to the POC.

Protocols and Tools for Education, Wellness, and Clinical Management. The client POC has specific educational goals that target areas of risk identified through the initial assessment. For maximum client response, our approach uses continual reinforcement of health enhancing messages through printed, Web-based, verbal, and Televox education. All eligible clients receive a Welcome Package introducing the program, NAL, and care coordination services. To ensure all clients have access to KEPRO tools, we use TDD/TTY to communicate with clients who are deaf or hard of hearing. For clients with visual impairments, we provide materials in alternative formats such as large print and audio tapes. Materials are written between a 4th and 6th grade reading level and are available in both English and Spanish. Written materials in other languages prevalent in Oregon---French, Korean, Russian, Cantonese, Mandarin, Somali, Swahili, Vietnamese, and Arabic--are available. We have access to the KEPRO corporate Language Line vendor to communicate with members in over 140 different languages.

Coordination and Management of Mental Health, Dental Health, Physical Health, Public Health Systems, and Long Term Service and Support Organizations. The KEPRO program model is person-centered to ensure that behavioral health; dental health; physical health; and LTSS needs are fully understood and integrated to ensure care coordination that addresses clients' comprehensive needs. Our ability to effectively coordinate services and manage comprehensive client needs is predicated upon a comprehensive assessment process and established and productive partnerships with health systems and support organizations across Oregon. Our coordination of behavioral health needs is supported by social workers and RNs who specialize in behavioral health and from KEPRO more than twenty years of behavioral health experience. Through extensive outreach to integrate OHA and DHS services with county Mental Health Agencies, we established referral processes with OHP Mental Health System, county Agencies, mental health counseling services with case management, and Crisis Lines.

KEPRO has found the current care coordination clients, often unaware of their dental coverage, have minimal utilization of dental care. Our comprehensive assessment includes dental history and current dental health, as people with periodontal disease are at greater risk of contracting systemic disease such as cardiovascular disease, and periodontal concerns are common with cardiac conditions and/or diabetes. We verify dental eligibility within MMIS, work with clients to understand their dental benefits, help them access dental plans, locate dental providers and free or reduced cost clinics or programs, and help set-up appointments. KEPRO has established relationships with the Oregon Dental Association and Advantage Dental.

We refer clients to free clinics, community health fairs, food banks/pantries, housing aid, utility aid, WIC, homeless shelters, domestic violence shelters, Meals on Wheels, free diapers, 211, free cell phones, vision clinics, dental clinics, free haircuts, free local exercise clinics, and reduced cost diabetic foot care clinic. We also connect clients with LTSS organizations such as the Living Well, Brian Grant Foundation, APD/AAA, Quitline, Shiba, Cancer support groups, and the Cervical and Breast Cancer Foundation. KEPRO has experienced great success integrating health and support services with Oregon housing support organizations.

Through a person-centered program model, KEPRO provides comprehensive care coordination services that leverage partnerships across Oregon to engage clients, enhance compliance with treatment plans, promote PCPCHs, support the provider community, and improve health and financial outcomes. By building relationships with community resources, we develop new and creative ways to coordinate care, improve clients' healthcare experiences, and achieve improved outcomes.

An example of the effect of our community presence is our collaboration with the *Housing with Services* organization, an LLC participating in the state SIM grant that supports HUD residents in obtaining help in other areas of their lives.

Our field-based nurses work with all willing, eligible clients at their 11 HUD facilities in the Portland area, assisting clients with the integration of their services, clinical and living supports. KEPRO works closely with the organization itself to set up integrated teams and is a member of its committee comprised of housing providers, CCOs, provider groups and KEPRO nurses.

The committee meets regularly to improve the lives of Oregonians in their HUD facilities and discuss successes and opportunities.

Specialized Approaches for Children. Novel Interventions in Children's Healthcare (NICH) is an OHSU-based program for youth with complex and chronic health conditions and family. It relies upon an intensive program of family-based skills training, care integration and coordination, plus resource and case management. KEPRO Healthcare and OHA have discussed mutual efforts to make this array of services available to children with these needs who are covered by OHP FFS Open Card. We are ready to implement this valuable program with OHA's consent. KEPRO Healthcare works extensively with people at the Department of Child Welfare, who are directed by Kevin George, in regards to managing care for children covered by OHP FFS Open Card who are in foster homes and have health care management needs. KEPRO Community-Based RNs assess these situations and the needs of the children and seek to coordinate services with DCW and other public and private entities to provide appropriate services. There are disparities in the care available for children in foster homes compared to other children, and KEPRO and OHA collaborate to advocate for the most appropriate services for these children. Child Welfare Services has identified lack of in-home nurses as a major issue for the children who need those services and requested these services to be included as a benefit, and with extensive experience in social services, KEPRO is ready to assist.

Copies of Forms and Tools Proposed for Use in Providing Care Coordination Services. **Exhibit 6** in includes examples of tools, many products of evidence-based guidelines incorporated into the system design, including a customized Initial Assessment; POC; and examples of IT functionality that drives targeted outreach and intervention. We also provide screenshots of our internal Provider and Resource Databases, as well as condition-specific action plans; educational materials; and client communications.

11. Independent and Qualified Agent Services (IQA)

INTRODUCTION. The 1915(i) State Plan Amendment process provides states with flexibility in the design and administration of programs to meet the needs of eligible individuals through a defined benefit of medical, behavioral health, and home and community-based services. Waiver services promote achievement of OHA goals, supporting individuals in their paths along recovery with improved quality of life, choice among high quality providers, and coordination of services that meet their needs. With active participation from individuals and their families, the plan of care is the roadmap to integrate necessary services and provide the framework for evaluation and quality improvement for waiver members. KEPRO is a leader in integrated care management for individuals with behavioral healthcare needs with over a decade of experience. KEPRO also provides comprehensive waiver management services in West Virginia since 2008. Our Oregon approach is based on these experiences, drawing on 20 years of experience in Medicaid behavioral health and our "person-first" culture.

KEPRO has extensive knowledge and experience throughout the State of Oregon regarding behavioral health services that may be used by clients served by the OHPCC Program. This knowledge extends to the Independent and Qualified Assessment (1915i) Behavioral Health Services. KEPRO and OHA had previously discussed the possibility of providing these services, so KEPRO completed extensive work in preparation. These efforts included discussions with Chad Scott (Adult Mental Health Services QA/UR Director for OHP), who is an integral part of the leadership for the services that will be included. Chad also is part of the bi-weekly meetings with KEPRO to discuss and plan ongoing operations and improvements to the OHPCC Program, with his particular interest and expertise being the mental health needs of the adult clients. KEPRO also met and collaborated on a limited basis with Michael Oyster, who is Director of the Adult Mental Health Initiative known as AMHI ("Aim-High"), which is designed to ensure that the right types of services are delivered at the right time to adults with mental illness. KEPRO leaders will evaluate staff from the current contractor, which provides some of the 1915i services for the State of Oregon. A key strategy for this project is to transfer responsibility for managing residential services to the Mental Health Organizations. The goal is to collaborate with MHOs is to improve coordination and community responsibility for adult mental health services at all levels of care in the system. An experienced MHO, KEPRO has the background to facilitate collaboration.

KEPRO will provide Independent and Qualified Agent (IQA) services to OHP members receiving home-based habilitation, home and community-based behavioral rehabilitation, and home and community-based psychosocial rehabilitation for individuals with chronic mental illness. We understand there will be approximately 2,200 individuals enrolled in the waiver and eligible for eligibility evaluations, assessments, care planning, and care coordination. Individuals will also receive other care coordination services as relevant, such as assistance with access to medical and dental care and care management interventions if they have co-occurring physical conditions. Staff conducting these activities will be Qualified Mental Health Professionals (QMHP), licensed in Oregon and meeting the requirements of OAR 410-172-0600. As we show in Figure 1, KEPRO proposes the position of Behavioral Health Assessments Manager to supervise IQA activities. The Job Description in **Exhibit 1 Resumes** shows that positions must be QMHPs with at least five years of relevant experience with Medicaid populations.

TRANSITION CONSIDERATIONS. KEPRO will work closely with the incumbent during implementation to identify and prioritize individuals who may be close to annual re-determination and/or re-assessment timeframes. We will discuss current service plans with the incumbent to ensure a seamless transition of responsibility for individuals, including if necessary, assistance from current Case Managers to transition to a new team. Where possible, and with the Agency's approval, KEPRO will transition incumbent staff to the new contract to enhance continuity of service for individuals and providers.

ELIGIBILITY DETERMINATION. The process begins for new clients with a determination of eligibility, or for already enrolled clients, with a re-determination of eligibility. Clients may be in the FFS population or enrolled with CCOs and receiving FFS waiver services. KEPRO will receive referrals for individuals who are potentially eligible through our online system as well as through telephone, in-person, or mail contacts. Regardless of the source of referral, the KEPRO Call Center and Case Managers will provide technical assistance to referrers and assistance with submitting documents as needed. The KEPRO system will provide the electronic database and interface to receive and track referrals. The referral and accompanying documentation will become part of the client's system record, available for review by the Agency, and this record will also house assessments, care plans, interactions with clients and providers, and other relevant information for analysis and reporting.

Communications And Outreach. KEPRO understands the importance of communication to stakeholders to promote appropriate referrals for the 1915(i) waiver, access to waiver services, and assistance with coordinating access to providers, services, and other resources. The Agency will review all materials and approve them in advance prior to distribution. Examples of communication materials include, for example, a Member guide, program announcements for stakeholder organizations, outbound calls and text messages (for individuals accepting text messages), and community presentations. We will also be proactive in educating providers about program changes and the KEPRO approach.

Communication Materials

- How to Make a Referral
- Eligibility Requirements
- Assessments
- Waiver Services
- Provider Responsibilities

KEPRO Oregon will receive support from corporate resources within KEPRO for content development, design, and formatting. We show the draft website in Figure 5. This site will provide user-friendly access to links for services and a provider directory. Additionally, clients will be able to contact KEPRO Case Managers, report a problem, and request assistance with access to care. As the illustration shows, there will also be a link to request assistance with making a referral.

Figure 5 Website Model for 1915(i) Services

KEPRO will also incorporate information from related entities for a multi-faceted provider resource. For example, KEPRO has a long history of close collaboration with the extensive network of publicly owned housing for extremely low-income individuals that provides a variety of social and health services. This program is in Multnomah County, where KEPRO Community-Based RNs and leadership have a successful relationship with Jan McManus, Deputy Director of Medicaid. KEPRO and the County have signed a memorandum of understanding to work collaboratively on providing the best care for all clients in Multnomah and the surrounding counties. KEPRO will work with county offices to develop a similar relationship.

Conducting Eligibility Determinations. KEPRO Case Managers, who are QMHPs licensed in Oregon, will be field-based and responsible to conduct the eligibility determination and face-to-face assessments with online access to the waiver system through the KEPRO information system. The Case Manager will evaluate the documentation and decide first if the documentation is sufficient to complete the determination. In the event documentation is missing, the Case Manager will

contact the referral source and if necessary, other individuals or providers. Once the documentation is complete, the Case Manager will determine if the individual has:

- A diagnosis of chronic mental illness as defined in ORS 426.495 and
- An assessed need consistent with the current or proposed level of care owing to a chronic mental illness.

The Case Manager will complete the eligibility determination and make an assessment using clinical information such as:

- A behavioral health assessment meeting the requirements of OAR 309-019-0135 that has been developed within the last 12 months prior to submission and is signed by a Qualified Mental Health Professional.
- A treatment plan or plan of care, meeting the requirements in OAR 309-019-0140, that has been developed within the last 12 months of the eligibility determination and is signed by a Qualified Mental Health Professional.
- Recent progress notes supporting need for the 1915(i) HCBS services.
- Any additional clinical information supporting medical justification for the 1915(i) HCBS services requested.

KEPRO will complete eligibility determinations within three (3) business days of receiving the referral; if the request is of an urgent nature, we will complete the determination within 48 hours of receipt. We will also contact the referral source within five (5) business days of receipt and schedule an independent assessment for each client determined eligible for 1915(i) HCBS services. On completion of the eligibility determination, we will respond to the referral within three (3) business days of the decision, and document the rationale for the decision. We will also include clear directions on requesting reconsiderations or appeals if the individual was not eligible, to ensure the referral source understands the available actions and next steps.

Eligibility Redeterminations. KEPRO will complete a redetermination at least every 12 months, and will respond within three (3) business days of a request for a redetermination. Documenting the determination date in the system allows us to provide 60 calendar days advance notice to individuals that an annual redetermination will be due to ensure that individuals have maximum flexibility in scheduling redeterminations. The system will queue redeterminations and assign them to field-based Case Managers on a regional basis. The Case Manager will automatically contact individuals and their service providers to gather information that facilitates a timely redetermination. The process for this determination will be the same the initial determination, with notification to the individual to include information on reconsiderations and appeals if found not eligible.

Internal Quality and Process Reviews. Case Managers will receive detailed initial training on conducting eligibility reviews using standardized documentation to allow us to generate inter-rater reliability statistics. Additionally, KEPRO will select a random sample of eligibility reviews on a quarterly basis, and will re-review of the determination to evaluate how well Case Managers followed standard policies and procedures and incorporated all available documentation in making the initial decision. As part of the initial review, we evaluate documentation and request additional information if the documentation is not complete. Additionally, when referrers offer additional information we will conduct a redetermination using that data.

Appeals of Eligibility Determinations. KEPRO will refer appeal requests to the Agency, and provide documentation and assistance in preparation for the appeal. The KEPRO Case Manager who conducted the determination will be responsible for this process and support the Agency in its review of materials. Agency access to the KEPRO system will also enable the Agency to review the determination record and attached documentation.

INDEPENDENT ASSESSMENTS. Contracted Case Managers will conduct the assessment, and complete it within 14 business days of the eligibility determination. KEPRO proposes to use our successful field-based model, currently in use in California, Ohio, and Florida Preadmission Screening and Resident Review programs (PASRR) for face-to-face assessments. We develop a consistent cohort of highly qualified individuals, validate their independence prior to assigning specific cases, and manage the field-based staff to ensure appropriate and timely performance; cultural competency; and validity of assessments.

Requirements for Independent Assessments. The purpose of the assessment is to evaluate all information relevant to individuals' functional status and service needs independently of providers that may deliver services to the individual. The quality and reliability of assessments depends on the knowledge and experience of the assessor and the rigor and reliability of the process. With over 10 years of experience conducting face-to-face assessments for people with chronic mental illness, our culture is recovery-oriented and culturally sensitive, supporting our proven process and ability to hire and retain highly accomplished individuals to perform assessments.

KEPRO conducted ***over 200,000 independent assessments and evaluations*** in 2015 for individuals with chronic mental illness, intellectual/development disabilities, and other disabilities.

KEPRO will provide a written guide that describes the assessment process and provides information about the waiver, and send it to individuals as part of the eligibility notification process. Independent assessments will follow these requirements:

- *Obtain informed consent for the assessment from individuals.* When Case Managers schedule assessments, they will request verbal consent, and provide a written consent agreement for the individual to sign prior to initiating the assessment. The consent will indicate that it is voluntary; part of the process to access waiver services; that data collected will not be used for any other purpose; that the individual may withdraw consent at any time, ending the assessment; and that eligibility for other Medicaid services does not depend on completing the assessment. Case Managers will review the consent form with the individual, and initiate the assessment after signing.
- *Support individuals during the process.* KEPRO will ensure that individuals have access to support from provider site staff or other individuals, to be comfortable in participating in the assessment. Case Managers will ask individuals if someone else should attend and informing them that, at any time during the assessment, they may pause the process and request assistance from a staff person or other individual.
- *Attendees at the assessment.* During the eligibility process, Case Managers will note if there is an authorized representative, and this representative will receive notice of the assessment schedule. Additionally, Case Managers will ask individuals if others should be consulted and/or present at the face-to-face assessment. Case Managers will consult with family members, guardians, treating professionals, friends, and others the individual identifies.
- *Inclusion of relevant materials.* Assessments inform and support the integrated service planning process, and therefore must reliably report on the functional status and service needs of individuals. Assessments must therefore incorporate all available materials and document findings based on those materials. In the process of preparing the assessment, Case Managers will review the eligibility determination, medical records, objective functional evaluations, previous assessments, and notes from waiver Case Managers if available. The Case Manager will evaluate the independence and reliability of the materials when reviewing them as part of the assessment.
- *Evaluation of individuals, environments, and contexts for service.* The formulation of integrated care plans must address the unique circumstances of individuals and therefore the assessment must reveal and examine these attributes. They include documented needs for medical and behavioral healthcare, individual strengths, preferences, and recovery goals, and available service, housing, and transportation options. Evaluating the availability and appropriateness of natural and paid supports is also important to understand how the care plan can combine all elements into a person-centered framework for recovery and independence. When unpaid caregivers will be part of the care plan implementation, the Case Manager will also conduct an assessment to identify issues that may affect the ability of the caregiver to continue safely and responsibly and the need for caregiver supports and resources.

Case Managers will also ask individuals if they have crisis plans, and if so, will invite them to share the crisis plans with KEPRO as a confidential part of their record. The purpose of this step is that, since providers and facilities have access to the KEPRO system, they would also be able to access the crisis plan if the individual is in crisis. Case Managers will also be able to provide access to crisis plans (if the individual agrees) to others in the event of a crisis.

Timing of the Service Plan. Case Managers will complete the person-centered service plan within three (3) days of completing the assessment. The service plan will be documented in the KEPRO system and distributed to the individual.

Training for Administration of Assessments. Our background includes utilization and case management programs for behavioral health services in nine states and KEPRO has organizational experience with service plans based on LOCUS and LSI assessments. We will train the Case Managers in the administration and interpretation of these tools and monitor their

administration through quality assurance for accuracy and completeness of assessments using the tools. KEPRO will share quality assurance reports with the Agency and provide training interventions when performance does not meet standards.

Conduct Independent Assessments. We will conduct assessments every twelve months, when individuals' status and/or needs change significantly, or as requested by OHA-HSD. KEPRO will provide advance notice to individuals when the re-assessment is due, and facilitate the assessment as we describe in this section.

PERSON-CENTERED PLANS OF CARE. The goal of eligibility review and assessment of eligible individuals is the development of a plan of care that accurately reflects the individual's unique situation, service needs, and goals for recovery. In this context, the independence of the process is instrumental to developing the care plan with the individual and relevant others. The Case Manager will be responsible to work with the individual and representative, if applicable, to develop and document a care plan based on the independent assessment. Case Managers will complete the care plan on a timely basis, and collaborate with individuals at their convenience in terms of the time and location for meetings to develop care plans.

How Individuals Participate in the Process. KEPRO has been a leader in promoting self-determination of individuals with chronic mental illness and/or intellectual/developmental disabilities, with experience administering programs in California, Georgia, Hawaii, West Virginia, Maryland, Maine, and Pennsylvania that validate and support self-directed planning. With this background, we understand that care plans must support goals that are important to the individual and incorporate services that will help individuals achieve those goals – and that the individual is the best person to develop the plan. Case Managers will therefore assist individuals with plans of care, incorporate information from others individuals choose to participate, and encourage individuals to make informed choices and decisions by explaining alternatives and options.

Providing Information During the Process. Case Managers will support individuals through the process, providing tools and information they need to understand and choose among service and other options. Case Managers will use clear and culturally appropriate language, and provide translation services for individuals who may have limited English proficiency.

Written Plan of Care. The outcome of the process is the written care plan, developed by the individual and documented by the Case Manager that details the individuals' expressed goals and desired outcomes, and supports achievement of those goals and outcomes with specific services (including providers, duration, etc.) selected by individuals according to their preferences and strengths. The KEPRO system will contain the plan of care to make it accessible to others as appropriate, and provide a hardcopy of the plan for the individual, representative, and relevant others.

Clinical and Support Needs. An important part of the plan of care will incorporate clinical (medical and behavioral health) services as well as other support needs, such as transportation or housing. KEPRO will maintain an updated list of service providers that are available in the individual's region so that the individual can easily chooses among different service providers. The care plan will also document paid and natural (unpaid) services and supports, and identify selected providers. KEPRO will encourage inclusion of community-based, peer-delivered services.

Risk Factors and Strategies. Care plans provide the framework and direction for services that individuals need to promote recovery and independence as well as address symptoms and care needs. Plans must account for a variety of situations and risks, and provide realistic alternatives to prevent barriers to care. Case Managers will evaluate risks such as loss of caregiver support, unavailability of providers, conflicts with providers, and crisis situations, and help individuals formulate action plans to address those risks. Strategies may include enlisting friends to act as caregivers; documenting second and third choices of providers in the care plan if the first choice is not available; or developing a crisis plan to file with KEPRO. Just as risks are unique to the individual, mitigation strategies will be specific to the individual and may change over time as circumstances change. Maintaining the care plan in the KEPRO system significantly facilitates this process, enabling the Case Manager to update care plans, electronically notify providers, and providing information individuals need about possible strategies.

Modifications. The assessment will identify specific needs individuals may have, and possibly require modifications to address the need. The Case Manager will document these modifications in the Care Plan, providing a rationale for the modification and noting the specific assessed need that supports the modification.

Ongoing Care Plan Review. The Care Plan will be reviewed and updated every 12 months, reflecting results of re-assessments, changes in support needs or circumstances, or request for review from the individual. KEPRO will monitor the timing of re-assessments; notify the Case Manager when a re-assessment is due; and prompt for updates to the care plan. Additionally, the system will alert Case Managers when claims or other data indicate the individual's circumstances may have changed so the Case Manager can evaluate the need for a re-assessment. Case Managers will then follow the same

consultative process to conduct re-assessments and/or make changes to the care plan. When individuals request a review of the care plan, the Case Manager will acknowledge the request within one (1) business day of receiving the request, and may schedule a discussion with the individual to review the care plan and make changes as requested.

MEDICAL APPROPRIATENESS REVIEW. Review of requested services for appropriateness of the level of care and type of service helps to ensure that services proposed are sufficient in nature, beneficial to the individual, and delivered in the least restrictive setting of care. Through its contracts in other states, KEPRO conducts over 1 million reviews annually to determine medical necessity and appropriateness of setting, and have review policies that support KEPRO's URAC accreditation for Health Utilization Management. We will adopt these best practice policies to ensure timely review.

Basis for Review. KEPRO will review services proposed in the care plan for medical appropriateness and compliance with OAR 410-172-0710 Personal Care, OAR 410-172-0700 Habilitation, using medical necessity criteria; OAR 410-172-0600 Mental Health Rehabilitation, OAR 410-172-0650 Prior Authorization, and OAR 410-172-0720 Re-authorization for Residential Treatment. KEPRO uses national standard criteria and local regulation to make medical appropriateness determinations. Different Case Managers will conduct medical appropriateness review than Case Managers who conduct eligibility determinations and assessments to ensure medical appropriateness reviews are independent. This approach is routine among KEPRO other waiver review programs as a system of "checks and balances" to promote process integrity. The KEPRO system will document the staff identifier of the Case Manager(s) who conducts the eligibility determination and assessment. Where possible, the same Case Manager will conduct both of these evaluations. The system will then automatically assign the medical appropriateness review to a different Case Manager.

Level of Care/Service Recommendations. Based on information in the eligibility determinations, independent assessments, plans of care, and supporting documentation stored in the KEPRO system, the Case Manager will evaluate the materials and create service recommendations for HCBS. The Case Manager will document the recommendation (specific services, providers, and units/duration in the recommended level of care), rationale, date/time, and reviewer identifier.

Determinations of Level of Care/Services. The KEPRO Case Manager will make a determination concerning the requested services, and document the review decision in the KEPRO system. For individuals receiving care in a licensed setting, the review decision will approve admission/continued stay or make a recommendation for discharge. The decision will approve the type and level of service for 1915(i) HCBS for each service requested for eligible individuals.

Communicate Level of Care Determinations/Approvals. KEPRO will use Agency forms for mental health rehabilitation, community-based habilitation, psychosocial rehabilitation services, personal care, and facility-based rehabilitation services. With the Agency's approval, we will create and store these forms in our system so that we can auto-generate them for submission to the Agency on a timely basis. Providers will be able to access the authorizations in the KEPRO system as soon as they are completed, and download service recommendations lists for their clients and manage service delivery efficiently.

TREATMENT EPISODE MONITORING. Using service determinations stored in the KEPRO system as well as claims and notifications from providers, we will monitor and track the length of stay for individuals who are receiving services in an OHA licensed behavioral health residential program. This process is important to help ensure individuals can transition back to the community as soon as possible, and that support will be available to make that transition safe and permanent. KEPRO will provide specialized care coordination services for individuals discharged from residential treatment to ensure that follow-up services are scheduled and delivered; that medications are available on a timely basis; and that other HCBS are in place to prevent readmissions. The KEPRO Call Center will assist with care coordination services, and will receive specialized training on transition of care services. When needed, the clinical Case Managers will assist with the process.

Reporting on Residential Utilization. KEPRO will report to the Agency on each individual's average length of stay including data points required by the Agency. We will routinely include individual identifier, residential program identifier, review data, admission date, length of stay for the individual as of the reporting period, and average length of stay for the program as of the reporting period.

12. Reports and Documentation

INTRODUCTION. Reporting is essential for effective care coordination. It is important to understand the health, demographics, care patterns, access problems, socioeconomic issues and specific interventions individuals need when receiving medical and support services. KEPRO routinely captures and reports program activities and their impact on client health, both at the individual and aggregate level. We use this information to analyze the eligible client population and create applicable outreach programs; define and refine the tools that identify and target individuals needing interventions; understand underlying health conditions and utilization trends; identify types of services clients utilize; and report the impact of care coordination on healthcare. Our analysis and reporting will build on reports refined by, deployed in the OHPCC program, and expanded to report on the IQA and other program changes.

The KEPRO system serves as the access point and central repository and maintains all information in a relational database. The system tracks and reports on a wide range of data, from client eligibility data to treatment planning and service utilizations, facilitating easy systematic access, retrieval and analysis of data. It transforms raw claims, pharmacy, assessment, demographic, eligibility, provider, financial/ accounting and other data into useful information and enables KEPRO to document all communications and interactions including information gathered through the assessment, treatment planning, or care coordination processes, as well as client interactions initiated through the Nurse Advice Line (NAL). Additionally external data sources, like publicly available industry data and standards or experience in other similar programs, may be utilized in the reporting environment to benchmark, measure performance and adapt the program. The system's integrated data tables are linked so that information on client acuity, service description and intensity, medication categories, diagnoses, ZIP codes, census data and eligibility data can be utilized for report development. Using this information, KEPRO employs a comprehensive set of analytic tools that range from predictive modeling to outcomes analysis.

APPROACH TO REPORTING. Using the included sample reports and the existing reporting package as a starting point, KEPRO will create, in collaboration with OHA and APD, a comprehensive reporting package that will: monitor quality of care; report outcome metrics to identify trends within population segments (e.g., high Emergency Department (ED) utilization for clients in their first 3 months of eligibility); monitor client service; identify high-utilization/high volume providers for additional outreach and education; and report on overall financial indicators and results. Reports will be segmented into relevant groups, i.e. Medicaid-only, Duals, transitional clients, clients who remain in FFS status, to facilitate understanding of different coordination needs, transitional requirements, health conditions and barriers to care. Upon identification of trends within population segments, KEPRO may target these populations for condition-specific outreach and education. Our proposed reports will be customized to the existing clientele and modified as the situation changes in Oregon. All reports will be created and used to help improve the client's health, improve health care delivery and experience, and lower the cost to Oregon. Sample reports are included in **Exhibit 8 Reports**.

KEPRO has a full-time reporting analyst dedicated to support OHPCC and help KEPRO, OHA and DHS understand the dynamics of the clients we serve. KEPRO also has a dedicated Healthcare Intelligence (HI) unit supporting OHPCC program and outcome analysis. Health Intelligence includes more than 25 analytical and clinical professionals focused on data analytics. HI specializes in healthcare data and analytic services; profiling, modeling, and trend analysis; evaluation design and implementation; program assessment and feasibility studies; performance measurement and quality assurance services; survey development and administration; and Fraud and Abuse detection. This unit also supports configuration of the Percolator for initial and ongoing identification and stratification of clients for care management interventions.

KEPRO uses the Business Objects software packages for query and development of reports, as well as SAS and SSRS. The software supports customized reporting, enabling information to be shared with others in a meaningful way across multiple functions and processes. KEPRO uses this product to create numerous individualized and specialized reports covering all aspects of OHPCC program operations. It is also used to create reports in a secure environment for instant access.

REPORTING TOPICS. We discuss reporting topics in this section, based on program requirements and information needed to ensure efficient program management.

Specific Health Indicators and Health Outcomes. KEPRO will collaborate with OHA and APD to develop key health and outcome metrics that align with State and CCO health outcome metrics. We recommend at least two formats: one comparing FFS to CCO metrics and the second a time-over-time view to identify positive trends in key indicators. Key CCO metrics for consideration with the OHPCC FFS program include all cause readmission, outpatient utilization, Emergency Department (ED)

utilization, hemoglobin A1c testing, follow-up after hospitalization for mental illness, and admission rates for selected disease categories such as COPD, asthma, CHF, or diabetes complications. We will segment these metrics into Dually Eligible and Medicaid-only clients to understand their specific needs and tailor specific interventions, and present quarterly reports of key health and outcome metrics to OHA and APD program management.

FFS Client Improvements or Changes in Health Status. Using all data sources including claims, assessments, census, and referrals, KEPRO stratifies all clients into risk categories (acuity level) at a minimum, monthly, and as frequently as daily. Improvements in acuity reflect interventions that improve client health status, utilization, and delivery of optimal care. We monitor these changes to evaluate success in client engagement, efficiency of meeting coordination needs, and manage allocation of coordination staff. Two sample reports in **Exhibit 8 Reports** show the net change in each acuity category for eligible clients and a targeted, drilled-down report, identifying clients with worsened conditions, to detect trends or possible causes for targeted interventions or QIP. Reports such as these are quarterly or monthly.

Interventions. To understand the needs of clients and ensure appropriate focus of coordination staff, we track and report providers and client interventions by type, the number of unique clients that received an intervention, and the success rate of each intervention. Depending on need, the interventions may be analyzed and reported specific to population segments (e.g., Duals, FFS, geographic location, conditions, or field vs. telephonic contact) to further target outreach and identify needed interventions. KEPRO tracks client interventions daily and recommends a quarterly presentation to program management with monthly, detailed operational reports to the program administrator.

Discharge or "Graduation" from Complex Medical Care. KEPRO generates reports to identify the number of clients with transitions from complex care coordination to a lower level of care coordination. On an ad hoc basis, KEPRO drills down those clients who have moved to a lower acuity level (discharged) to evaluate successful interventions, causes for discharge, and other characteristics. These reports are summarized at quarterly program administration meetings and periodically reviewed during regular coordination meetings.

Ambulatory Sensitive Conditions. As part of our Quality Program, KEPRO tracks ambulatory sensitive conditions such as COPD, asthma, and diabetes. Using claims analysis, we identify and track admissions related to those conditions and drill down analyses to understand additional factors that contribute to these admissions. We use this to target interventions to create positive changes in health status and reductions in potentially unnecessary admissions. KEPRO typically reports these formally to OHA on an annual basis.

ED Utilization and Inpatient Hospitalization. We will report utilization as a comprehensive historical (time-over-time) analysis and in comparison with utilization for clients enrolled in the CCOs. When we identify anomalies or trends, we will drill down to additional levels of detail to discover root causes and possible confounding factors. We will also report separately for Duals and Medicaid-only populations and as specified by OHA and APD. KEPRO reports utilization information on a quarterly basis to OHA.

Complaints, Resolutions, and Compliments. KEPRO promptly resolves complaints. We review complaints during regular operational meetings and present a quarterly summary report at the OHPCC management meetings. KEPRO also reports compliments and success stories during bi-weekly operational meetings and at the quarterly administration meetings.

Enrollment Activity. KEPRO tracks and reports the number of new clients, ineligible clients, clients currently engaged, clients in current outreach, and total eligible clients. One area of focus is tracking newly enrolled individuals, their immediate care needs and usage, and their transition to CCOs, as these clients tend to have an overuse of ER visits. KEPRO proposes reporting enrollment activity during quarterly OHA meetings.

Disease or Condition and Co-morbidity Prevalence. In conjunction with change reports listed above, KEPRO analyzes and reports the prevalence of disease/condition types and co-morbidities. We use these findings to understand the population's greatest needs, track changes over time, develop QIPs, revise clinical focus, and create additional outreach programs. The process evaluates disease inter-relationships to create a comprehensive plan of care for clients. We present this report quarterly at the OHA meetings.

Referrals. KEPRO receives referral information from the Nurse Advice Line (NAL), hospital discharge coordinators, state case managers, and medical and service providers. We use referral information to identify and ensure clients receive the care, support, and coordination assistance they require. We also use this information as a measure of our interaction with other state and community providers, to ensure that all parties stay engaged. The sample **Referral Report** included in **Exhibit 8**

Reports addresses not only hospital discharge but also subsequent follow-up interventions. Referrals are tracked by type and compiled as a formal quarterly report that is presented at the OHA meetings.

Utilization of Program Services. KEPRO includes a variety of client services, interventions and activities in its care coordination program. We group various care coordination services into categories to understand how we are interacting with clients and the impact of those interventions. We prepare and present the formal report quarterly at the OHA meetings and it is often a foundational piece of our QIP proposals.

Community and Service Provider Outreach. On a daily basis, KEPRO works with state employees, providers and community support groups in the field. Outreach varies from providing education, coordinating service needs with medical care, arranging transportation, assisting providers with state service approval, joint-discharge planning with hospital staff, etc. KEPRO monitors these interactions to ensure prompt client follow-up, maintain and improve strong relationships, and to make sure regular communication and visits occur with all community medical and support groups. KEPRO reports community and provider outreach as part of the quarterly OHA meeting.

Telephone Triage and Advice Line Services. Carenet (further described in Section 9) delivers nurse triage and advice line services. KEPRO ensures Carenet meets program metrics and provides appropriate services, and that clients receive a rapid and smooth transition to our Oregon-based care coordinators. In addition to required performance reports, we will generate and analyze additional reports to support NAL activities such as frequency of guideline use by symptom category, caller demographics, triage disposition, and cost avoidance. We report these activities and Carenet's call center statistics quarterly at OHA meetings.

Care Coordination Program Effectiveness and Efficiency. KEPRO evaluates program effectiveness and efficiency in many ways. We complete and analyze reports including timely completion of assessments, high level of service at the call center, improved health outcomes, successful engagement of clients, cost savings, and removal of barriers to care. The KEPRO management team uses these regular performance reports to evaluate and improve each area. KEPRO routinely looks for new ways to differentiate and evaluate eligible clients. We also examine consistently eligible members compared to those that quickly move to CCOs or lose eligibility and tailor outreach to the short-term opportunity to engage and educate them.

Financial Indicators, Program Costs, and Expenditures. KEPRO reports financial indicators and costs according to the specifications and terms of a specific contract. We generate these reports annually with interim updates as required. While programs vary in their financial requirements and methodologies, we have developed analysis specific to the current OHPCC program and have included an example of this savings reconciliation report.

IQA Activities. KEPRO will develop new reports to capture performance on the IQA scope of work. These reports will include, for example, volume and timeliness of eligibility determinations, assessments, medical appropriateness reviews, and notifications; approvals of services specified in care plans by type and level of care; unique number of clients in each level of care; average length of stay in residential settings; admissions and readmissions to residential care; and other metrics such as the number of clients with active crisis plans stored in the KEPRO system. As with all reports, KEPRO will prepare draft formats for Agency review, and will schedule and produce reports as the Agency approves.

SPECIALIZED DATA COLLECTION AND REPORTING. Hospital Census information is a critical part of the care coordination, disease and intensive case management services. It provides one of the highest value opportunities for intervention into the lives of clients to provide high impact assistance in the transition of care between the care they received as an inpatient or ER patient to care at home or in some other healthcare or residential institution.

KEPRO established relationships with virtually every hospital and health system in Oregon for provision of census information through secure email or faxes that relates to the OHP Open Card clients. There is a daily process and protocols for evaluating the clients identified through this process and assigning those who need to be contacted by a KEPRO RN Health Coach to offer assistance in their transition of care. PreManage is an expansion on the EDIE program used by every hospital in the states of Oregon and Washington to extract and share Inpatient and ER patient information on a real-time basis. KEPRO is preparing to implement PreManage in the OHPCC Program in the first half of calendar year 2016 to build upon the Census Program that they have developed and used quite effectively during previous contract period.

13. Evaluation and Health Outcome Measures

INTRODUCTION. KEPRO have improved health and healthcare outcomes across the country for more than 20 years, including the current contract with OHA since 2009. KEPRO applies nationally established and recognized benchmarks and standards including HEDIS™[ii] (Healthcare Effectiveness Data and Information Set) measures to evaluate the effectiveness, access, and efficiency of care, allowing us to compare program performance to that of Medicaid populations nationally. In Oregon, we will continue to work closely with the State to establish outcome metrics aligned with client needs, operational processes, and CCO metrics that demonstrably improve healthcare, client experience, and individual wellbeing. We will enhance our outcomes tracking and reporting to include metrics appropriate to the 1915(i) initiative, including average length of stay, for example. Our approach is informed by data to close gaps in care and shape a healthier population. Oregon's Triple Aim is our framework: improving health; improving healthcare; and lowering cost through transforming healthcare delivery.

Use of evidence-based practices, interventions, and strategies. Guideline sources include, for example, the Centers for Disease Control; National Institutes of Health; and the Global Initiative for Chronic Obstructive Lung Disease (GOLD) Standards. We also incorporate guidance from specialty societies and associations such as the American College of Cardiology; American Heart Association (AHA); American Diabetes Association (ADA); American Psychiatric Association; American Academy of Pediatrics; American Academy of Family Physicians; American Academy of Orthopedic Surgeons; American Society of Addiction Medicine; and the U.S. Preventive Services Task Force. As an organization with experience in aging, behavioral health and intellectual/developmental disabilities, our methodology is deeply informed by advocacy and provider associations regarding services, tools, and systems to help individuals achieve and maintain independence.

Percolator. Percolator technology systematically applies algorithms using validated, evidence-based, and published metrics. On a daily basis, the system applies triggers pulling from a library of over 3,000 triggers to identify instances of uncoordinated care and need for support, e.g. daily living needs or HCBS to remain independent in the community. Based on findings, the system automatically prioritizes outreach and workflow for the Care Management Team. The benefit to the population is an equitable daily analysis of medical, behavioral health, and HCBS needs and gaps in care based on diagnoses, claims, and clinical/functional assessments. KEPRO customizes and updates the Percolator using the State benefit plan, program goals and priorities, and population characteristics. KEPRO uses industry-standard definitions for performance measures, and customizes additional definitions based on contract specifications, e.g. the CCO metrics in Oregon.

Evidence-based Resources. We define readmissions as all-cause readmissions within 30 days of an acute hospital discharge and use the Prevention Quality Indicators (PQI) published by the Agency for Healthcare Research and Quality to measure avoidable admissions and readmissions. We identify non-emergent (neER) visits to the ED using the algorithm published by Wagner School of Public Service at New York University. Risk scores incorporate the Chronic Illness and Disability Payment System (CDPS), published by the Regents of the University of California, San Diego. Target metrics, based upon evidence-based guidelines including HEDIS measures, are built into the system and direct plans of care and interventions. Evidence-based resources include:

- Chronic Obstructive Pulmonary Disease (COPD) – Global Initiative for Chronic Obstructive Lung Disease.[iii] Strategy for the diagnosis, management and prevention of COPD. HEDIS: Pharmacotherapy Management of COPD Exacerbation
- Sources: American Heart Association, heart failure performance measurement set and American College of Cardiology Foundation/AHA Practice Guidelines.[iv] HEDIS: Preventive measures only: Percentage of CHF members assessed for tobacco use, assistance with tobacco cessation, influenza and pneumococcal vaccination.
- Diabetes - National Institute of Diabetes and Digestive and Kidney Diseases. National diabetes statistics.[v] HEDIS: Testing hemoglobin A1c; Controlling HbA1c Level; Screening for Serum Cholesterol Level (LDL-C Screening); Controlling Serum Cholesterol Level Examining Eyes for Retinal Disease; Monitoring for Kidney Disease.
- Asthma - NHLBI; Guidelines from the National Asthma Education and Prevention Program: Expert Panel Report 3[vi]. HEDIS: Use of appropriate medications for people with asthma; Medication management for people with asthma; Asthma medication ratio; Relative resource use for people with asthma.

- Coronary Artery Disease (CAD) - Task Force on Practice Guidelines.[vii] HEDIS: Relative Resource Use for People With Cardiovascular Conditions, Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia, Persistence of beta blocker Treatment after Heart Attack, and Annual LDL-C.

ACHIEVING OUTCOMES. The foundation of KEPRO programs is prevention aligned with best practices. KEPRO emphasizes the client-care source relationship as critical to the development of self-care skills. We help clients find medical homes, and support client adherence with provider care plans. At the start of a care management program in Missouri with over 100,000 members, only 3% of members had a medical home. By contract end, 99% of enrolled members had a medical home and we achieved a 7.8% reduction in total annual costs ($155 million) and a 44% reduction in inpatient utilization vs. projections. We also achieved an increase in medication adherence (pharmacy utilization asthma medications and cardiovascular medications); an increase in recommended diagnostic testing (HA1c, lipid panel, etc.) across all targeted disorders; and a significant improvement in appointment attendance. Outcomes were validated by Mercer.[viii]

KEPRO focuses on service coordination to maintain community tenure and avoid facility placement; access to the NAL provides health and medical advice that clients can use to improve health literacy and avoid ER visits. Since 2007, KEPRO has decreased lengths of residential and inpatient stay in the Maine Behavioral Health community. The KEPRO contract achieved $48 million in savings in its first two years was achieved by working with the State of Maine to reduce residential lengths of stay. Our ability to help clients remain independent is also evidenced by reductions in avoidable ER use and inpatient admissions. KEPRO utilization metrics show on average our programs have resulted in a 10% reduction in ER use and an 8% reduction in inpatient utilization. In a care management program in Wyoming serving over 70,000 members with chronic disease, we reduced avoidable hospitalizations for clients with CHF from 103.2 to 93.0 per 1000M (members); for asthma, we reduced ED visits from 151.2 to 103.0 per 1000M and hospitalizations from 19.7 to 8.0, and readmissions from 2.8 to 0.7. For diabetes, we reduced ED visits from 114.0 to 104.3; hospitalizations from 30.3 to 24.8; and readmissions from 4.2 to 2.5 per 1000M. This program achieved over 19% ROI of $47 million.

Another similar care coordination program drove an ER utilization decrease from 732.9 visits per 1,000 members in the general Medicaid population to 617.4 per 1,000 in SFY14. The inpatient admission rates significantly decreased from 149.6 in SFY13 to 127.2 in SFY14 for the Medicaid population without duals and from 175.1 to 154.3 ER visits per 1,000 with duals. Improved HEDIS measures for SFY14 include: ER utilization rate for those with asthma for dual and non-dual population; appropriate controller medication (ASM) use for those with asthma for dual and non-dual population; HbA1c testing for members with diabetes non-dual population; ACE/ARB medication for members with CHF, non-dual population and dual population; and LDL-C testing for members with CAD, non-dual population.

Financial. KEPRO is credited with saving the State over $38 million in this program. We deliver reductions in healthcare costs through Return on Investment (ROI) for similar programs, showing savings ranging from 2.3:1 to 8.7:1. In Oregon, we improved the majority of performance metrics. We achieved positive ROI for each of the first five years, including one year of the dual-eligible clients in the program. The aggregate ROI for all five years including both groups of clients was 3.1:1. The savings for the State during the five years is estimated to be over $80 million.

Reductions in progression of chronic conditions and acuity of catastrophic medical events.

Diabetes. For diabetes, we improve glycemic control and help clients learn to control blood pressure. Sustained reduction of HgbA1c levels produces positive clinical outcomes as well as reduction in costs over time.[ix] We provide education on blood glucose management and the importance of HA1c testing, eye and foot exams. We conduct three-way calls to schedule appointments and provide Diabetes Action Plans—developed using evidence-based guidelines by nationally recognized sources (AHRQ AHA, ADA)—to be completed with the client and the medical home. Our coaching helps to prevent or defer complications of diabetes such as end stage renal disease (ESRD), and the chance for catastrophic medical events such as amputation, which threaten clients' community tenure. In Oregon diabetes education by nursing staff, referrals to community resources such as Living Well, instruction in diet modification and exercise, and glucose monitoring instruction and support have achieved low rates of admissions for diabetic short-term complications (less than half the benchmark). We initiated a quality improvement project targeting HA1c results. In Pennsylvania Access Plus, KEPRO reduced ED visits by members with diabetes from 114.0 to 104.3; hospitalizations from 30.3 to 24.8; and readmissions from 4.2 to 2.5 per 1000 members.

COPD. Care for clients with COPD focuses on self-care; risk factor reduction; and prevention and management of exacerbations. We educate clients on the use of peak flow meters and recording values, and we teach that cough, sputum

production, and breathlessness are not trivial symptoms. We help clients monitor exposure to risk factors, and we address lifestyle factors such as smoking cessation, proper medication and proper use of oxygen. A systematic review of studies on risk factors for hospitalization and readmission of COPD patients shows that patients who routinely fail to seek therapy for exacerbations are more likely to be hospitalized.[x] KEPRO provides COPD Action Plans and education on preventing exacerbations, reinforcement of medication compliance, and assistance with durable medical equipment (DME). In our Vermont program with 2,200 high-risk/high-cost engaged members, COPD medication adherence was 75.8% among those members engaged in KEPRO care management, compared to 58.9% for non-engaged members. For clients with CHF, our interventions focus on self-care as recommended by the AHA: medication adherence; eating a low sodium diet; exercise; and active monitoring of signs and symptoms such as increasing edema. We provide teaching on co-morbid conditions (HTN, dyslipidemia, diabetes), if appropriate, and instruction in activity level, diet, medications (Beta-blocker and/or ACEI/ARB), and weight monitoring. We ensure clients attend appointments and teach what to do if symptoms worsen. Additional interventions include assistance with smoking cessation and with obtaining influenza and pneumococcal vaccines. Multi-disciplinary disease and care management has been shown to reduce recurrent hospitalization and improve quality of life in people with CHF.[xi] The multidisciplinary Care Teams and our increased focus on provider engagement will include communication between KEPRO and providers about clients with CHF as part of the provider scorecard process that we recommend include the CHF Admission Rate (discussed more in 5.4.3).

Asthma. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication. Research shows that appropriate medication management for patients with asthma reduces the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions and missed days of work or school.[xii] Our interventions include provision of an Asthma Action Plan, in accordance with the Centers for Disease Control and Prevention. The plan is written and completed with the medical home. Our intervention strategies are based on clinical guidelines from The National Asthma Education and Prevention Program, coordinated by the National Heart, Lung, and Blood Institute of the National Institutes of Health. We incorporate the asthma stepwise approach as published by the National Heart, Lung, and Blood Institute that is based on a four-part classification of disease severity and the client's control of the condition, which fluctuates. In Oregon, we decreased the young adult asthma admissions through self-care education, assessing use of long acting inhaled steroids, and education on the use of rescue inhalers and peak flow meters.

CAD. KEPRO interventions for clients with coronary artery disease (CAD) focus on self-care, getting proper exercise and modifying diets to lower cholesterol. Our support follows AHA Standards of Care for CAD, with a focus on monitoring blood pressure and cholesterol. HEDIS measures for CAD include Relative Resource Use for People With Cardiovascular Conditions, Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia, Persistence of beta-blocker Treatment after Heart Attack, and Annual LDL-C. The Framingham Heart Study has provided evidence that hypertension, dyslipidemia, body mass, and cigarette smoking are all determinants of cardiovascular risk that are modifiable through disease and case management.[xiii] Dietary interventions such as the DASH diet can reduce blood pressure, which in turn, can reduce risk for CAD and the associated morbidity and mortality.[xiv] We address dietary modifications and increase the intensity of educational interventions with clients in DM or ICM who are overweight and sedentary.

OUTCOMES FOR CHRONIC CONDITIONS. KEPRO outcomes over a two-year period from 2011-2013 (validated by KEPRO and URAC, when program accredited) show 4 out of 5 KEPRO Care Management programs achieving over a 5% reduction in asthma ER utilization; 3 out of 5 meeting NCQA national standards for Rx use in CHF members; and 4 out 5 programs showing a 5% improvement in appropriate Rx use for CAD members. All programs tracked during this study met NCQA national standard for Medication Management for Depression. The outcomes of the OHPCC program to date promote Oregon's Triple Aim goals.

KEPRO improved health at the membership level with reduced rates of ER usage and rates of readmissions for any cause through our census reporting process; early intervention after daily identification of gaps in care; medication reconciliation; appointment coordination; and transportation coordination.

14. Quality Control and Process Improvement

INTRODUCTION. Our Quality Improvement (QI) Process evaluates, manages, and improves the quality and value of care coordination. Formal quality improvement is a consistent and ongoing process involving thoughtful observation, data driven identification of quality improvement initiatives, benchmarking, analysis, and corrective action. We use the QI Process systematically to monitor and evaluate the adequacy and appropriateness of services and continuously improve performance. The foundations of our program are comprehensive and integrated treatment plans developed in collaboration with clients, their support systems, and treating providers; integration of available benefits through coordination of care; and optimal services for clients, as measured by positive outcomes, cultural appropriateness, and client satisfaction.

QUALITY CONTROL AND PROCESS IMPROVEMENT PROGRAM. KEPRO maintains a national QI Process to support our multi-program URAC accreditations and to provide the foundation of our customized individual programs. The KEPRO QI Process incorporates operational metrics; nationally recognized guidelines, standards, and benchmarks; and systematically collected feedback from stakeholders into a formal program that measures, manages, and improves quality. The KEPRO corporate structure, policies, and procedures, aligned with URAC accreditation for Health Utilization Management, Case Management, and Disease Management form the basis for the QI Process. Local Operating Policies adapt the corporate policies and procedures to the specifics of each contract to ensure that QI focuses on the needs, goals, and opportunities of the local program. National and local QI staff collaborates to recognize and address QI opportunities. The national QI Process assures sharing results across programs to identify best practices, and monitoring of program requirements to ensure KEPRO exceeds expectations. This approach brings the best of our national and local QI Process together to achieve program goals and improve outcomes for clients. In this section, we present and discuss the QI Process we propose for the OHPCC program.

Assessing the quality, timeliness, and appropriateness of care coordination services. KEPRO has proven systems that proactively ensure the timeliness, quality and appropriateness of care coordination services. Our technology identifies barriers to care and creates priority workflows for efficient intervention. To ensure the on-going effectiveness of our systems and processes, QI assures achievement of contractual standards and assesses service impact through outcome evaluation and client feedback obtained through call monitoring, compliment/complaint analyses, and satisfaction surveys. We objectively monitor operational metrics using claims information and stakeholder feedback. Our technology uses programmed triggers to identify care coordination needs and the QI program ensures that identified triggers are successfully resolved. For example, if the trigger is the lack of a routine source of care, KEPRO connects the client with and provides education on how to use a medical home effectively thereby closing the trigger. To ensure the intervention was effective, claims analysis must validate more appropriate utilization and engagement following the intervention. Assessment of care coordination quality and appropriateness uses definitive measures such as: 1) the number of clients whose health status improved (moved from a higher to lower level of severity) or worsened (moved from a lower to higher level of severity) during the reporting year; 2) an analysis of the reduction in ER utilization; 3) avoidance of nursing home placement; and 4) the results of client knowledge/health literacy, satisfaction surveys, and improvement in ability to manage one's own health and healthcare as measured by the PAM survey.

Assessing the Nurse Triage and Advice Line Services. The Nurse Advice Line (NAL) helps clients determine the most appropriate healthcare option for acute symptoms, emphasizing prevention and patient education. For OHPCC, it has a 79% ER avoidance rate and resolves 30% of calls by providing clients with information on self/home care. NAL services are delivered through an agreement with Carenet. KEPRO monitors NAL services for quality, timeliness and appropriateness and is responsible for achieving all contract requirements. NAL services are fully integrated into our workflows and the KEPRO Clinical Operations Manager directly supervises its performance and reports quality metrics to the Local Quality Improvement Committee. The NAL Automated Call Distribution (ACD) system uses real-time monitoring to manage call flow, traffic, trunk usage, etc. Reports provide call statistics by program, employee and/or system in real-time. KEPRO analyzes key metrics to ensure the achievement of URAC standards and alignment with program goals.

Employee performance. Staff monitoring and development focus on factors such as appropriately assessing behavioral and social risk factors that may negatively impact health status; promoting client independence; engaging and guiding clients in their care plans; using behavioral change strategies to educate and motivate change in unhealthy behaviors; providing education on specific health risks; assisting with goal establishment; and strategies to overcome barriers to achievement. Ongoing staff quality monitoring is accomplished through activities associated with performance metrics such as: silent monitoring and review of recorded calls for content and responsiveness (100% of calls are recorded); complaint analysis; treatment plan reviews to assess the level of client/family engagement, inter-disciplinary provider involvement and

incorporation of clinical best practices; and achievement of definitive productivity measures (volume, timeliness, and follow-up) that consider the intensity of delivered interventions. We develop improvement plans as needed to maintain compliance with all contract, state and federal requirements. QI plans address issues such as staff training, new policy development, and resource allocation adjustments.

Clinical documentation auditing. Quality audits sample timely and accurate record keeping. We audit a minimum of 3-5 cases per employee each quarter. Our tool addresses 20 points including: obtaining appropriate consents; client participation in treatment planning, goal setting, and care progression; and delivery of client assessments, education, training and outreach interventions based on client need. A passing score is ≥90. In 2014, we conducted 597 audits for Oregon staff with an average score of 97. Staff members not receiving a passing score undergo additional audits, customized training, and other actions as necessary to improve employee performance. Clinical documentation audit scores are discussed during the employee's regular one-on-one coaching sessions and during his or her annual performance review. We will include the 1915(i) eligibility determinations, assessments, care plans, and medical appropriateness reviews in our documentation audits in the new contract, and base auditing standards on our internal best practices model as well as using OHA's requirements.

Silent Monitoring for Content and Customer Service. Call monitoring ensures we deliver consistent and accurate, client-friendly services. Monitoring results are included in the staff coaching sessions and annual performance evaluation and are used to identify potential QI activities. KEPRO monitors a minimum of two calls per month for staff who achieve a passing score (≥90). Staff members who do not achieve a passing score receive additional training and undergo a minimum of five audits/month until a achieving a passing score. We monitor employee performance at the individual and aggregate level using a standard score card that identifies internal performance metrics by position as shows.

Table 3 Metrics Used to Monitor Performance
Internal Performance Metrics Model

	CM	DM	DMC	CB	LPN
Productivity					
Call Volume	20/day	25/day	35/day	15/day	20/day
Assessments	2/day	5/day	N/A	2/day	N/A
Activity	30/day	40/day	50/day	35/day	40/day
Quality					
Call Monitoring	90%	90%	90%		90%
CDA Audits	90%	90%	90%	90%	90%
Past Due Follow Up	0/7 days	0/7 days	0/7 days	0/7 days	0/7 days
Past Due Contact	90%	90%	90%	90%	90%
System Proficiency	90%	90%	90%	90%	90%

Subcontractor performance. KEPRO uses both formal and informal methods to closely measure and evaluate subcontractor performance, including review of accurate, timely deliverables; teleconferences; participation as observers in subcontractor activities; customer and client feedback; and corrective action, if necessary. We provide feedback using key performance indicator reports. We ensure that subcontractor employees receive annual training related to compliance such as HIPAA; Code of Conduct/Conflict of Interest; Fraud, Waste and Abuse (FWA) Prevention, Privacy and Security. Additionally, subcontracts include "flow down" requirements from our contract with the State to ensure seamless compliance with contractual requirements and performance standards.

HOW KEPRO SHARES INFORMATION WITH OHA-MAP AND DHS-APD. KEPRO shares information through formal communications such as: targeted monthly reports, comprehensive quarterly reports, and an annual report that summarizes contract performance, identifies utilization trends, details population demographics, and presents QI plans and goals for the upcoming year. In addition to written documentation, KEPRO uses an interactive, collaborative approach to working with OHA-MAP and DHS-APD. For example, the Executive Director, Medical Director and Operations Supervisors participate in bi-weekly status meetings with the OHA Contract Administrator and other OHA/DHS leaders. These meetings are face-to-face and provide the opportunity to discuss updates on the status of the program. We present the month's activities, outcomes and trends compared to previous periods, and upcoming activities. We also present compliments, concerns and complaints; program trends, and status reports on Quality Improvement Project (QIP) initiatives. Using this open exchange of information, KEPRO is able to quickly respond to OHA/DHS requests for information and develop strategies to achieve program objectives and continuous quality improvement. Examples of key items which have been discussed in past meetings include: sharing concerns regarding utilization (e.g., dental visits, prenatal care) together with suggestions for addressing the issues; aligning KEPRO and CCO performance metrics; establishing key points of contact to support on-going communication and collaboration in the achievement of shared goals and initiatives; facilitating transition of clients from FFS to CCO enrollment

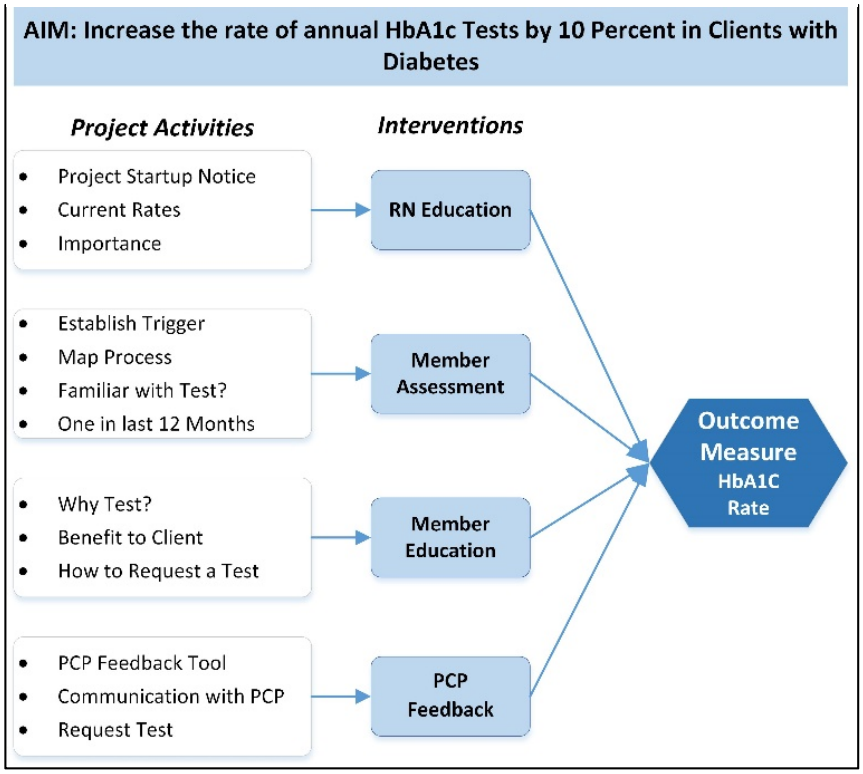
through secure exchange of information and identification of priority needs; and clarification of contract intent to ensure compliance is maintained. KEPRO will continue to collaborate with the OHA-MAP, DHS-APD and inter-related programs through participation in committees and workgroups. This includes ongoing participation of KEPRO representatives in State committees, such as the Metrics and Scoring Committee, the OHA Board of Directors meeting, and other appropriate events.

APPROACH TO QUALITY IMPROVEMENT PROJECTS (QIP). KEPRO develops QIPs when we identify opportunities for improvement through ongoing quality assurance monitoring. Development, implementation, evaluation and reporting of QIPs are core components of the KEPRO quality program. The QIPs target priorities that emerge from clinical data, such as HEDIS measures that are below external comparison benchmarks. Clinical QIPs may include, for example, prevention or care of acute or chronic conditions, high-volume or high-risk services, or continuity and coordination of care. Service QIPs may focus on issues such as availability, accessibility, or cultural competency of services.

A Local Quality Improvement Committee is responsible for determining the prioritization of QI initiatives and activities based on an assessment of risk to the clients, impact on the largest portion of utilizing clients, client satisfaction, and state input. The LQIC develops the method for measuring the activities and baseline data; the content of the report; the aggregation of the data; the establishment of goals and thresholds for the monitor; the review and analysis of the data; the identification of opportunities to improve clinical care or service; and the formulation of recommendations to improve performance. Each QIP uses data that is valid and reliable to:

1) Develop quantifiable measures.
2) Establish measurable goals for improvement.
3) Establish timeframes for improvement.
4) Measure current levels of performance.
5) Design and implement strategies to improve performance.
6) Re-measure progress in meeting QI goals.
7) Conduct barrier analysis when expected improvement is not achieved.
8) Revise interventions as necessary.
9) Repeat implementation of strategies using revised interventions.
9) Report results using valid statistical principles and analysis.

Figure 6 Framework for QIP



As shown in Figure 6, KEPRO developed a QIP for Oregon to increase the rate of the yearly A1C measurement in diabetic clients by 10 percentage points. We describe the QIP in **Exhibit 9 QIP Example.** In **Exhibit 10 Complaints & Resolutions,** we provide examples of complaints and grievances received, and our person-centered methods to resolve those issues.

15. Cost Proposal

KEPRO includes our Cost Proposal following the tab labeled Attachment G.

15.1 Attachment G Part 1 - Nurse Triage and Advice Telephone Services

15.2 Attachment G Part 2 - Care Coordination and Case Management

15.3 Attachment G Part 3 - Independent and Qualified Agent Services

15.4 Attachment G Part 4 - Performance-based Payments

16. Public Record/Confidential or Proprietary Information

KEPRO is not designating any confidential or proprietary information.

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[i] Chronic Illness and Disability Payment System (CDPS). Published by the University of California, San Diego. Copyright © Regents of the University of California 2014.
[ii]HEDIS® is a registered trademark of the National Committee for Quality Assurance
[iii]Global Initiative for Chronic Obstructive Lung Disease. 2014. "Global Strategy for the Diagnosis, and Prevention of Chronic Obstructive Pulmonary Disease." (June 9, 2014)
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